## edical Economics



Office Ownership: Is It Worth the Cost?

Also in this issue: Ways to Leave Money to Your Heirs How Long Before You're Safe from Suit?

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1. Eichner, E., Goler, G. G., Sharzer, S., and Horowitz, B.: Obst. & Gynec. 6:511, 1955. 2. Greenblatt, R. B., and Brown, N. H.: Am. J. Obst. & Gynec. 63:1361, 1952.

## **Medical Economics**

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JUNE, 1957

#### SPECIAL FEATURES

Is	Your	Hospital	Ur	to	P	ar?	 .1	1	1

In staff and services, does it compare favorably with the average institution of its size? These charts will help you tell

#### Taking a Vacation, Hmm?

Any doctor can plan for a holiday, says this confirmed optimist. On the other hand, if you ever want to leave home . . .

#### 

The second of a series of articles discussing the type of training and the practice methods that tie in with clinical competence

#### 

Medical-lay symposium roughs out some guidelines for dealing with an age-old question that seems to have no pat answer

#### 

This study shows that while the quality of obstetrical care has been steadily rising, its relative cost has been declining

-MORE

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SPECIAL FEATURES (Cont.)	
The Truth About Unnecessary Operations1	97
Who are the doctors who do needless surgery and why are they so often able to get away with it?	
Surgeon at the Sacrificial Altar	30
It was just a thyroidectomy—but to those awestruck natives, it meant a very real battle between supernatural powers	
Medicine Chest for a Trip Abroad2	66
What to take with you in case of a medical emergency—and how to pack it without messing up baggage or adding bulk	
YOUR PRACTICE	
Office Ownership: Is It Worth the Cost?	50
It's no cheaper than renting. But it nearly always results in a more rewarding medical practice—personally and financially	
How Long Before You're Safe From Suit?16	64
Patients sue doctors on at least five different grounds. Here are the statutory time limits on each in the various states	
Why Some Collection Letters Don't Collect	75
Often it's because they contain phrases that rub most people the wrong way. Here are nine such phrases that it's wise to avoid	
Are You Training Future Competition?18	12
If you take on an M.Dassistant, it's sensible to protect your practice from later competition with a restrictive covenant	
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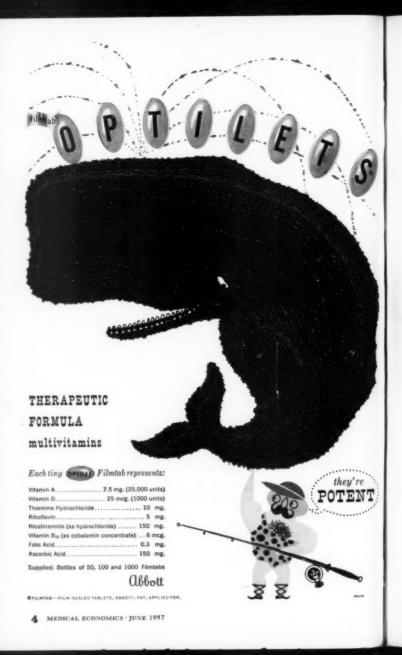
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CONTENTS
YOUR PRACTICE (Cont.)
Tips on Talking With the New Patient222
The first visit is the best time to let him see that you consider nim a person, not just another medical case
How to Get People to Accept Your Advice242
After studying patients' reactions to what doctors told them, his man has come up with five good tips on advice-giving
YOUR FINANCES
Can You Pass This Business Quiz?145
Fest yourself on these multiple-choice questions, then compare your answers with the correct ones given on page 148
Ways to Leave Money to Your Heirs212
When and how they inherit your estate is often just as im- portant as the amount they get, says this well-known attorney
SHORT FEATURES
Patient Data Form Aids Collections
One sure way to create a collection problem is to bill the wrong person—a minor child, say. Here's what you can do about it.
Malpractice Mishaps: The Well-Meant Quip142
The doctor had a wonderful sense of humor. Unfortunately, his udgment of the proper time to use it wasn't quite so acute
ANNOUNCEMENT
The 1957 Medical Economics Awards192

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#### NEWS

#### VIEWS

Why People Borrow	80	Ten-Cent Bargain	82
Mail Call	80	Voice with a Smile	84
#1 Insurance	81	All Is Not Gold	86
Delayed Exposure	81	Free Rx Blanks	86

#### OTHER DEPARTMENTS

Letters 46	Publisher's Memo 352
Subject Index331	

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- 1. Zimmerman, F. T., and Burgemeister, B.: Arch. Neurol. & Psychiat. 72:720, 1954.
- 2. Zimmerman, F. T., and Burgemeister, B.: J.A.M.A. 157:1194, 1955.
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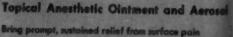
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## News

#### Fees From Polio Shots Go to Medical Schools

When you give polio shots, should you collect your usual fees? Or should you regard the anti-polio campaign as something out of the

**E** 

Baker

ordinary and do something special with any proceeds? Doctors across the country have come up with a variety of answers to these questions — and one of the most interesting is the answer worked

out by the Pueblo County (Colo.) Medical Society.

Pueblo doctors are donating their services in an intensive vaccination program. Sponsoring groups are paying for the vaccine—and also paying \$1 per injection to the Pueblo County Medical Society. In one month, over 1,200 citizens were given their first injections.

What's the society doing with the proceeds? At their April meeting, Pueblo doctors voted to forward the money to the American Medical Education Foundation. With it, they sent a list of the society's 112 members and their medical schools. The A.M.E.F. was asked to distribute the money according to the proportion in which each school is represented among Pueblo physicians.

The society's president, Dr. William N. Baker, adds: "We hope to collect at least \$2,500 for the A.M.E.F. And, whatever we get, we'll try to match it with further individual contributions."

#### 'Greed' of Specialists Rapped by G.P.

It's dog eat dog in the medical profession today—if one of the dogs happens to be a specialist. At least that's the view of Dr. Julian B. Cole, president of the Kentucky Academy of General Practice. He contrasts this state of

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"Seventeen years ago, when I was a medical student," he says, "a skin specialist cauterized a wart on my forehead and refused to charge a fee. I politely insisted that he take the money for this service. After a moment . . . he said in a brotherly manner, 'Cole, in this business, dog doesn't bite puppy.' I left his office feeling . . . that medical men composed a brotherhood . . ."

Today that feeling has faded. Dr. Cole goes on: "There isn't very much individual friendship if there is any competition between those individuals." If some specialists seem to be friendly with some G.P.s, "they are not competing against one another." Instead, "they may be leeching one another. You will see the specialist and the general practitioner being great buddies providing the practitioner is feeding the specialist mill with patients."

Who killed the feeling of bro-

therhood in medicine? Dr. Cole blames the type of specialist who feels a "great concern . . . for the patient [and] wants [him] to have the best. In other words, the specialist . . .

"Take this example. There are three large hospitals in a central Kentucky city. The [local] obstetricians and gynecologists have decided it unwise for the patient to have her baby delivered by anyone other than a specialist . . . They have persuaded one of the

hospitals to absolutely forbid any general practitioner to use its delivery room. They have gone to great effort to get the other two hospitals to do likewise. They [say they] are doing all this to



Cole

protect the patients. Everyone there who has seen the shenanegans that have been pulled thinks it the

#### Snapshots

TWENTY-FIVE-YEAR TREND: The number of government civilian employes has been growing three times as fast as the country's labor force. If this continues, says the newsletter of New York's First National City Bank, "in the year 2069 we will all be working for the government."

FEWER FREE HOSPITAL BEDS are needed for the medically indigent, Dr. Walter C. Bornemeier of Chicago believes. Many such people now have health insurance, he points out; they're medically indigent only because they can't pay for out-patient care—which their insurance doesn't cover.

OCCUPATIONAL HAZARDS became acute recently for two obstetricians in Palermo, Sicily. After a woman had died in childbirth, irate relatives tried to lynch the two doctors. They climbed through a window, made off in a car, cracked up, finally escaped on foot.

MALPRACTICE MENACE in Washington, D.C., has spurred the medical society to schedule monthly luncheons at which members will discuss ways to avoid suits. greatest display of GREED ever witnessed.

"When I think of the pioneer women who delivered their own babies in the morning and cleaned up the mess in the afternoon I am almost nauseated by the asinine ego of this specialty group," Dr. Cole concludes. "The Kentucky Academy of General Practice is making great strides to prevent this type of robbery."

#### Congress Writes Off the Special Doctor Draft

The doctor draft law is due to expire this month. And Congress may at last be willing to let it die in peace. Under active consideration a month ago was a simple amendment to the regular draft law, according to which doctors would be conscripted on much the same terms as other citizens.

The present law makes physicians liable to conscription even when they've had prior military service. It makes them draft-eligible long after they've passed what for other Americans is the age of safety.

Some time ago, A.M.A. witnesses told Congress that the special doctor draft "discriminates against physicians... by singling them out from the entire body of citizenry and subjecting them to special and double liability for military service." They recommended that Congress enact "an amendment to the

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basic draft law which will permit the selection of physicians for military service from among regular registrants."

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The proposed new amendment follows that recommendation. H.R. 6548, as it's called, is "in substance . the program of the American Medical Association," says the A.M.A. Board of Trustees.

Assuming the amendment is passed, what then?

"There'll still be a degree of discrimination against physicians," says Joseph Stetler, head of the A.M.A. law department. "The selective service system can pick out the names of doctors instead of just reaching into a fish bowl and drawing out a hundred names and hoping to get the five doctors they need.

"But," he points out, "the doctors they call up will be in the same age category as everybody else. And they won't be doctors who've had previous service."

#### 'Why Can't Blue Cross Cover Mental Ills?

Are psychiatric patients getting their money's worth out of hospital insurance? The answer, according to the National Association of Private Psychiatric Hospitals, is a resounding no. Here's how Dr. Eugene N. Boudreau, chairman of the association's Prepaid Health Insurance Committee, describes the situation:

#### Snapshots

PENALTIES FOR PATIENTS who abuse the National Health service have been proposed by British doctors. These would be only fair, they say, in view of the "savage penalties inflicted on doctors" for infraction of Health Service rules.

EMERGENCY-CALL SERVICE has been made compulsory for members of the San Joaquin County (Calif.) Medical Society. Both G.P.s and specialists who don't sign up voluntarily are put on a compulsory list to take twenty-four-hour duty in rotation, answering calls the volunteers can't cover.

TAX EVASION is no longer considered a crime involving "moral turpitude" in Georgia. That state's revised Medical Practice Act specifically rules out tax evasion as one of the things that could cost a doctor his license.

TOP-LEVEL ASSISTANT at his country's first operation involving use of an artificial heart was Brazilian President Juscelino Kubitschek, who practiced surgery before entering politics. In this case he assisted an American, Dr. Earle B. Kay of Cleveland, Ohio.

"Of the eighty-five Blue Cross plans in the United States and Canada, only five give full coverage of mental and emotional illness. Partial coverage (usually only token benefits) is provided by forty-five plans; and thirty-five plans give no coverage . . ."

As Dr. Boudreau figures it,

about 45,000 Blue Cross subscribers annually are hospitalized for the first time because of mental or emotional illness. But Blue Cross pays the hospital bills for only about 3,600 of these people. The other 41,400 "get little or no coverage," Dr. Boudreau says. This means, he adds, that "41,400 peo-

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#### More Specialists Are Movi



Big-city practice seems to be losing some of its appeal for specialists-particularly for the younger specialists. Cities of more than half

a million population have attracted over a third of the specialists who graduated from medical school in 1935, but less than a fourth of

those Mean practi 000 p ple pay Blue Cross premiums but don't get any benefits when they need them. Their premium dollar goes to the surgical patient, the medical patient, and the obstetrical patient."

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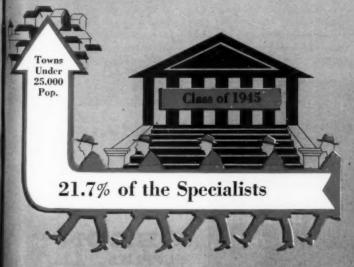
This peo-

Of these 41,400 patients, Dr. Boudreau goes on, many probably went to the hospital believing their

policies would pay their expenses. They'd probably seen the full-page ad in the Saturday Evening Post in which the Blue Cross Commission asserted "all the basic hospital services and many extras are provided for."

Comments Dr. Boudreau: "What do those 41,400 patients

#### s Are Moving to Smaller Places



those who graduated in 1945. Meanwhile, the proportion who practice in places of less than 25,000 people has jumped almost 50

per cent. Source: a study by Weiskotten and Altenderfer for the Association of American Medical Colleges, 1956.

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think when they are told that they can collect no benefits? This does not fulfill the American spirit of justice and fair play."

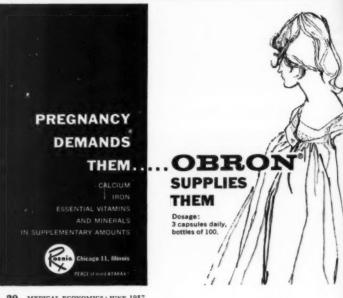
He sees no good reason why Blue Cross-and Blue Shield tooshouldn't pay for psychiatric care. "The common argument against including mental and emotional illnesses in voluntary prepaid health insurance," he notes, "is that it would be too costly. Doesn't the experience of the Group Hospital Service in Dallas, Tex., give the answer? It has been operating successfully since June, 1939; it gives full coverage of mental and emotional illnesses, as well as alcoholism and drug addiction. In 1955,

the cost of all these benefits came to less than 3 per cent of the plan's total costs."

#### New Rules Set for **Staff Meetings**

The Joint Commission on Accreditation of Hospitals has established new rules for hospital staff-meeting attendance-and they're not what the A.M.A. asked for.

Up to now, active staff members have been required to attend 75 per cent of all staff meetings unless excused for just cause. This standard for hospital accreditation has been widely objected to. Last year, the A.M.A. House of Delegates form-



20 MEDICAL ECONOMICS · JUNE 1957

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#### SIX REASONS WHY PHYSICIANS ARE RECOMMENDING KOTO-Flex



FIG. 1



FIG 2

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FIG. 3

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ally resolved that "the attendance requirement should be set up locally and not by the Commission."

But the Joint Commission insists that every hospital must have rules governing attendance at its meetings. "In order to make certain that these rules are adequate," it believes, "the Commission should furnish a specific yardstick." Here's the new yardstick established by the Commission:

"Active staff attendance shall average at each meeting at least 50 per cent of the active staff who are not excused by the Executive Committee for just cause. Each active staff member shall attend 50 per cent of staff meetings unless excused by the Executive Committee for just cause."

This, medical leaders point out, is a substantial modification-but still a far cry from the complete local autonomy urged by the A.M.A.

#### U.S. Medicine Through A Hungarian's Eyes

Ever wondered how American medicine looks to a physician who has always practiced under the Communist system? To find out, MEDICAL ECONOMICS recently interviewed Dr. Leslie Bakos, one of the Hungarian doctors who fled to this country after the recent revolution. Dr. Bakos, presently with the Tu-

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berculosis Hospital in Madisonville, Ky., by now has been here long enough to get his bearings.

His biggest surprise has been the high quality of doctor-patient relations in America. "Here," he says, "a doctor really knows his people, and that's of very great therapeutic value." As a state-employed G.P. in Budapest, Dr. Bakos cared for 3,000 patients and was required to refer any out-of-the-ordinary cases. He had neither time nor opportunity to know his patients personally.

The hardest thing for him to get used to is the free economy of American medicine. Hungarian doctors, he explains, "must work at least twenty-four hours a week, but they can see private patients in the evening. Since they're paid by the state, they have no right to collect fees. The patient voluntarily puts whatever he can afford into a plain envelope and hands it to the doctor." American physicians are better businessmen, as Dr. Bakos sees it.

Though he strongly prefers the American system, he notes that so-cialized medicine does have one advantage: "It's a great thing for the lower middle class, those who don't get free medical care and can't afford to pay full price. But the American way is superior in other respects." [MORE NEWS ON 284]

In the anemia of pregnancy....

"The combined use of iron and cobalt [Roncovite] produces better clinical results, apparently by maintaining normal marrow function and by supplying adequate amounts of iron."\*

\*Holly, R. G.: Iron and Cobalt in Pregnancy, Obst. & Gynec. (Mar.) 1957.

IN PREGNANCY, AS IN ALL IRON DEFICIENCY ANEMIAS, THE BIBLIOGRAPHY SPECIFIES

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all through the night



one application of

# **OINTMENT**

helps protect the infant's skin against

diaper rash (ammoniacal dermatitis) • irritation • excoriation



DESITIN OINTMENT covers the infant's skin with a soothing, protective, healing coating which is largely impervious to and helps guard against irritation, rash, and maceration caused by urine, excrement, perspiration and secretions. This preventive action of Desitin Ointment persists all through the night ... when baby is particularly vulnerable to painful skin excoriations.

Nonsensitizing, nonirritant Desitin Ointment . . rich in cod liver oil .... successfully used on millions of infants for over 30 years.

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DESITIN CHEMICAL COMPANY Providence 4, R.I.

 Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. Med. ( 53:2233, 1953.
 Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
 Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949.
 Turell, R.: New York St. J. Med. 50:2282, 1950. 5. Marks, M. M.: Missouri Med. 52:187, 1955.

MEDICAL ECONOMICS · JUNE 1957 25

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1957



### This Low-Fat Breakfast is Well Balanced

The importance of an adequate morning meal has gained wide recognition. That breakfast should be adequate not only in calories, but also in its content of essential nutrients, is advocated by medical as well as nutrition authorities even when recommending that the fat intake in the diet be lowered.

The foods commonly eaten at breakfast—fruit or fruit juice, cereal, milk, bread and butter—are also the foods comprising a basic breakfast pattern which has found wide endorsement by nutrition authorities. As shown below this breakfast pattern provides well-balanced nourishment and is low in fat and low in cholesterol,

#### BASIC CEREAL LOW-FAT AND LOW-CHOLESTEROL BREAKFAST PATTERN

Orange juice, fresh, ½ cup, Cereal, dry weight, 1 oz., with whole milk, ½ cup, and sugar, 1 tsp., Bread, white, 2 slices, with butter, 1 tsp., Milk, nonfat (skim), 1 cup, black coffee.

#### Nutritive Value of Basic Cereal Breakfast Pattern

Calories		*											×		5	02	R	
Protein														2	0	.5	è	gm.
Fat														1	1	.6	,	gm.
Carbohyd	a	10									,			8	0	.7	*	gm.
Calcium			 					.,					0		5	32	t	gm.
Iron										 	 	 			2	.7	,	mg.
Vitamin A				*								 . ,		6	0	0		ı. U.
Thiamine.								*						0	.4	46	•	mg.
Riboflavin.														0	.1	BO	)	mg.
Niacin				*	*						 	 			3	.0	)	mg.
Ascorbic A	ci	đ												6	5	.5	1	mg.
Cholestero	d.					0 1	0 1		0	0		0		3	2	.9	•	mg.

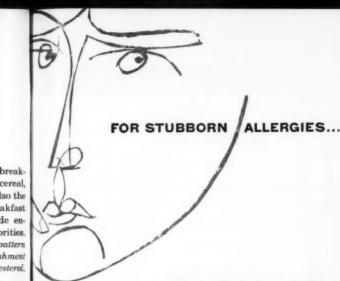
Note: To further reduce fat and cholesterol use skim milk et cereal which reduces Fat Total to 7.0 gm. and Cholesterol Total to 16.8 mg. Preserves or honey as spread further reduces Fat and Cholesterol.

Bouers, A. deP., and Church, C. F.: Food Valuar of Partinu Commonly Used 8th ed. Philadelphia: A. deP. Bouers, 1956. Great Institute, Inc.: The Natritional Contribution of Breakfast Cereals. Chicago: Great Institute, Inc., 1959.
Hayars, O. B., and Rass, G. K.: Supplementary Food Computation Tables, J. Am. Diests. A. 33:264, 1957.

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Meti-steroid benefits are potentiated in

#### METRET

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NASAL SPRAY prompt nasal comfort without jitters or rebound

#### ESPECIALLY FOR RESISTANT AND YEAR-ROUND ALLERGIES

Because edema is unlikely with the tablets and sympathomimetic effects are absent with the spray, METRETON Tablets and Nasal Spray afford enhanced antiallergic protection in vasomotor rhinitis and all hard-to-treat allergic disorders - even in the presence of cardiorenal and hepatic insufficiency.

#### COMPOSITION AND PACKAGING

Each METRETON Tablet contains 2.5 mg. prednisone, 2 mg. chlorprophenpyridamine maleate and 75 mg. ascorbic acid. Bottles of 30 and 100.

Each cc. of METRETON Nasal Spray contains 2 mg. (0.2%) prednisolone acetate and 3 mg. (0.3%) chlorprophenpyridamine gluconate in a nonirritating isotonic vehicle.

Plastic squeeze bottle of 15 cc.

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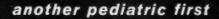
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CHOLARACE
Formula: (in the coating) 20 mg. racephedrine

Formula: (in the coating) 20 mg. racephedrine HCl, 27.5 mg. pentobarbital, (in the core) 200 mg. choline theophyllinate (Choledyl®).

**Indications:** Bronchospasm associated with or due to asthma, hay fever, emphysema, bronchitis, bronchiectasis, and to pulmonary infections in general.

**Average dosage:** Adults, 1 tablet every 3 to 4 hours. Children, 10 to 15 years of age, 1 tablet every 4 hours.

Supply: 100, 500 tablets

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The excellent clinical results obtained with Cholarace are based on the superiority of each of its three components. Choledyl is better tolerated than oral aminophyline. Racephedrine produces less CNS stimulation than ephedrine. Pentobarbital has faster and shorter action than phenobarbital.



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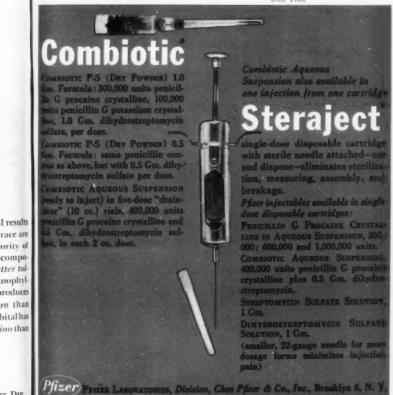
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Macaroni, Tomatoes, Beef & Bacon
Vegetables & Bacon
Vegetables, Egg Noodles & Chicken
Vegetables & Beef
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Vegetables & Bacon
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#### The <u>new</u>, exclusive Heinz Junior Breakfast

- This new idea is already a hit! A breakfast just like Daddy's, it's an easy way to help baby make the often-difficult switch from strained foods to adult food.
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80 er-Tasting ls One of the safest, least toxic and most effective therapeutic agents for many conditions in which the weaker tranquilizers or sedatives are inadequate

# Serpasil (reserpine CIBA)

On the following pages you will find information on these aspects of Serpaell therapy:

Tho growing uso of Sarpasii in overyday

practice

seprets of Serpasil there

PAGE 2 hypertension
3 emotional disorders
4 techycardia
4 alcoholism
5 acute hypertensive crises

6 side effects and precautions

8

acute psychotic disturbances

#### in hypertension



#### Serpasil® can always be considered first

- BECAUSE alone: Serpasil successfully reduces blood pressure, slowly and safely, in about 70 per cent of cases of mild to moderate hypertension.<sup>1</sup>
- BECAUSE as a "primer": Serpasil may be advantageously used to begin antihypertensive therapy, however severe the case, since it gently adjusts the patient to the physiologic setting of lower pressure.
- BECAUSE as a "background" agent throughout other therapy: Serpasil permits lower dosage of the more potent antihypertensives needed for refractory cases, thus minimizing the incidence and severity of side effects.

USUAL DOSE: Initially, two 0.25-mg. tablets. After a week, daily dose should be reduced to 0.25 mg. or less for maintenance.

"...a useful agent for the treatment of certain types of hypertension....The action...was increased by combining it with [Apresoline]..."<sup>2</sup>

<sup>1.</sup> Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955.

<sup>2.</sup> Winsor, T.: Ann. New York Acad. Sc. 59:61 (April 30) 1954.

## in emotional disorders



## Serpasil®provides true emotional control

In your daily practice there are undoubtedly many patients whose degree and type of emotional disturbance—characterized by overexcitation, anxiety and agitation—can not be adequately controlled with sedatives or weaker tranquilizers. These are the patients whom you can help most with once-a-day administration of Serpasil. For Serpasil actually sets up a "stress barrier" against anxiety and tension the patient would otherwise find intolerable. With Serpasil you can control the emotional turmoil of disturbed individuals; and because Serpasil is restricted to prescription use, control remains in your hands.

Although it is a first choice in hypertension, Serpasil does not significantly lower blood pressure in normotensive patients.

USUAL DOSE: Initial range is 0.1 mg. to 0.5 mg. (two 0.25-mg. tablets) daily. As little as 0.1 mg. is sufficient for maintenance in some patients. Serpasil can be given in a single daily dose.

"...relieves anxiety and irritability and calms the patient so effectively that because of this latter property alone, the drug should remain in the medicinal armamentarium."

Finnerty, F. A., Jr., and Sites, J. G.: Am. J. M. Sc. 229:379 (April) 1955.

## in tachycardia



## Serpasil® slows the rapid heart

Many patients can benefit from the heart-slowing action of Serpasil. Those in whom tachycardia is deleterious are helped by its unique bradycardic effect, for Serpasil prolongs diastole and allows more time for the myocardium to rest. Blood flow and cardiac efficiency are thus enhanced.

USUAL DOSE: 0.1 mg. to 0.5 mg. (two 0.25-mg. tablets) daily. After one or two weeks dose may be reduced.

"Reserpine [Serpasil] was found useful in relieving the tachycardia and emotional symptoms associated with cardiac arrhythmias, thyrotoxicosis, neurocirculatory asthenia, and even coronary heart disease."

Halprin, H.: J. M. Soc. New Jersey 52:616 (Dec.) 1955.

## in alcoholism



## Serpasil relieves drink-inducing tension

As a part of long-term therapy, oral Serpasil helps the alcoholic "stay on the wagon" by relieving drink-inducing tension, making him more amenable to your counseling.

In acute alcoholism, delirium tremens can generally be controlled within 24 hours with parenteral Serpasil... without the addicting or soporific dangers of drugs such as paraldehyde.

USUAL DOSE: Chronic phase: two 0.25-mg. tablets or less daily. Acute phase: two 2.5-mg. parenteral doses (1 ml. each) 3 or more hours apart. Occasionally, repeat injections of 2.5 mg. every 4 to 6 hours may be necessary.

"...the tranquilizing and anxiety-relieving properties of this drug [Serpasil] offer the possibilities of its being extremely helpful for the long-term therapy of the chronic alcoholic."

## in acute hypertensive crises



## Parenteral Serpasil®

Serpasil can be used alone in hypertensive emergencies or as a background to more potent antihypertensive agents. Its antihypertensive action is prompt and well-tolerated.

USUAL DOSE: 2.5 mg. (1 ml.) intramuscularly. Additional intramuscular doses of 2.5 mg. may be given as necessary every 8 to 24 hours.

"...appears to be [a] treatment of choice for hypertensine crises."

Griffin, R. W., Stover, J. W., and Ford, R. V.: New England J. Med. 254:593 (March 29) 1956.

# In acute psychotic disturbances



## Parenteral Serpasil

The family physician is often called to subdue and arrange for quick hospitalization of patients who suddenly experience violent psychotic episodes. With intramuscular Serpasil these patients are quickly tranquilized and rendered amenable to 'quiet' hospitalization.

USUAL DOSE: 5 mg. intramuscularly followed, if necessary, by another 5-mg. intramuscular dose in 90 minutes.

"It is now possible to discreetly manage acutely disturbed psychiatric patients by the prompt administration of adequate doses of reserpine (Serpasil)."

Ayd, F. J., Jr.: The Pharmacologic Management of Everyday Psychiatric Problems (A Scientific Exhibit). Presented at the Clinical Meeting of the American Medical Association, Boston, Mass., Nov. 29 Dec. 2, 1955.

# Serpasil:

The side effects of Serpasil are characteristic of all rauwolfia preparations.

Although millions of patients have taken Serpasil over the past several years, very few serious side reactions have been reported. There have been no cases of blood dyscrasia, liver damage, addiction or withdrawal symptoms. When patients are properly selected and the lowest effective maintenance dose is established, the physician can prescribe Serpasil confidently, with little fear of untoward reactions.

DEPRESSION Mental depression, which has developed in a small percentage of patients treated with rauwolfia, should be differentiated from the transient change in mood or physical fatigue that is experienced by almost everyone in the general population. It should also be distinguished from the lethargy experienced by some patients on rauwolfia therapy.

In the few cases in which mental depression does occur, there is some question as to whether or not it is a direct effect of rauwolfia. According to Mayo Clinic investigators,1 the evidence indicates that rauwolfia per se does not cause depression, but rather that it unmasks an underlying susceptibility to depressive reactions. Kinross-Wright<sup>2</sup> states: "It is likely that depression will occur only in a predisposed individual or in one who is already mildly depressed." Ayd; in a very recent paper, states: "That this drug may cause depression is uncertain. After reviewing a large number of so-called drug-induced depressions it appears that in some cases what was called depression was excessive tranquilization, while in the rest, the patients were depressed before the drug was started, and what the drug did was make the depression more ap-

Whether or not it is an effect of rauwolfia, physicians and responsible members of the patient's family should be on the alert for the development of side effects and precautions

symptoms of depression, particularly in patients with a history of pre-existing depressive tendencies. Daily doses above 0.25 mg. are contraindicated in the latter group. On withdrawal of rauwolfia, depression usually disappears, but active treatment, including hospitalization for shock therapy, has been required in some cases.

Adjunctive use of mood-elevating agents such as Ritalin is often sufficient to reverse mild depressions or drug-induced lethargy.

OTHER SIDE EFFECTS In addition to lassitude or drowsiness, other mild side effects of Serpasil include occasional nasal stuffiness and increased frequency of defecation and/or looseness of stools. Rarely, anorexia, headache, bizarre dreams, nausea and dizziness occur. With parenteral Serpasil there is a possibility of marked hypotensive effect; therefore, the blood pressure should be taken before injection and the patient kept under observation for 5 or 6 hours thereafter. Because initial doses above 0.3 mg. tend to increase gastric secretion of hydrochloric acid, daily doses above 0.25 mg. are contraindicated in patients with a history of peptic ulcer and lower doses should be used with caution.

For further details on side effects and precautions, write Medical Service Division.

 Litin, E. M., Faucett, F. L., and Achor, R. W. P.: Proc. Staff Meet., Mayo Clin. 31:233 (April 18) 1956.
 Kinross-Wright, V.: Wisconsin M.J. 55:1073 (Oct.) 1956.
 Ayd, F. J., Jr.: Presented at the Sesquicentennial Convention of The Medical Society of The State of New York, New York City, Feb. 18, 1957.

SUPPLIED: TABLETS, 0.1 mg., 0.25 mg., 1 mg., 2 mg. and 4 mg. ELIXIRS, 0.2 mg. and 1 mg. per 4-ml. teaspoon. PARENTERAL SOLUTION: Ampuls, 2 ml., 2.5 mg. Serpasil per ml., Multiple-dose Vials, 10 ml., 2.5 mg. Serpasil per ml. APRESOLINE® hydrochloride (hydralazine hydrochloride

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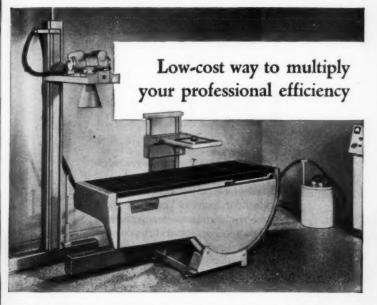
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"A well-tolerated treatment which is . . .
of considerable value in decreasing bacterial
activity and . . . nasal inflammation."

—A.M.A. Arch. Otolaryng. 62:354, 1955.

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"Good to excellent clinical response
... marked anti-inflammatory action ...
did not cause local irritation."

—A.M.A. Arch. Otolaryng. 60:431, 1954.

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'VASOCORT SPRAYPAK' contains hydrocortisone and 2 decongestants. While "most of the old nasal vasoconstrictors have proved ineffective," 'Vasocort' reduces inflammation, edema and congestion in acute, chronic and allergic rhinitis with virtually no burning, stinging or rebound turgescence. Also available as 'Vasocort' Solution for use by dropper.

aboratories. Philadelphia 1

1, M. Times 83:1003, 1955.

'VASOCORT SPRAYPAK'

# can you read this thermometer?

2 4 6 81 100

Naturally not. Missing calibration makes it worthless.

Equally useless and dangerous is a "quantitative" urine-sugar test that does not quantitate dependably, or omits readings in the critical range.

Enzyme urine-sugar tests are sensitive and specific for glucose-excellent "yes" or "no" tests but undependable for quantitation. King and Hainline, after testing 1,000 urines, found an enzymatic urine-sugar test unable to distinguish in the important range between ½ per cent and 2 per cent or more of urinary glucose. Leonards, in a report on 4,020 tests, revealed that "...in 502 out of 804 tests the wrong interpretation was made." He concluded that enzymatic urine-sugar testing "...as a quantitative procedure is unsatisfactory and can lead to serious error in the interpretation of a patient's clinical condition."

Failure to recognize this limitation of enzyme tests may result in incorrect insulin dosage,<sup>2</sup> and may lead to diabetic complications.

(1) King, J. W., and Hainline, A., Jr.: Commercial Glucose Oxidase Preparations for the Detection of Glucose in Urine, Cleveland Clin. Quart. 23:212, 1956. (2) Leonards, J. & Evaluation of Enzyme Tests for Urinary Glucose, J.A.M.A. 152:260 (Jan. 26) 1957.

reliable readings throughout the critical range—does not omit 34% (+++) and 1% (++++)

color calibrated CLINITEST

a 15 year "standard" in urine-sugar testing



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These are the new 51 gauge elastic stockings by Bauer & Black -fullfashioned stockings with threads twice as thin and twice as light.

Yet, sheer and glamorous as they are, they give the scientific kind of support you prescribe. Their fullfashioned construction provides graduated support from the ankle up, thus speeding the flow of blood from the legs.

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Whether your patient wants ultrasheer 51 gauge or stockings for in-formal everyday activities, she'll find them in the complete Bauer & Black line.

To be sure of patient coopera-tion, doctor, aren't these the elastic stockings to prescribe? At drug, department, and surgical supply stores . . . from \$6.90 to \$16.95 the pair.

MAIL COUPON FOR NEW COMPREHENSIVE DIGEST, "ELASTIC STOCKING COMPRESSION IN THE THERAPY OF VARICOSE VEINS," WRITTEN BY A DOCTOR, FOR DOCTORS

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A new
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with inherent safety
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# HYDROLAMINS

AFTER
Same case after treatment with Hydro-

Same case after treatment with Hydrolamins. Note healing of the inflamed, fissured and excoriated areas and of the whitened anal folds.

TOPICAL AMINO ACID THERA

Unique physiologic barrier—topical amino aci brings rapid relief (98%1) and complete bealing (88

- "...the objectives of therapy in pruritus ani can bell under 3 headings:
- (1) relieve itching: [Hydrolamins produced immed relief of intractable itching in 98% of patients. anti-pruritic effect of one application lasts at twenty-four hours.<sup>1</sup>]
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Due to the rapidity of action of Hydrolamins, it is belithat protein-precipitating irritants, responsible for pruritus, are neutralized. Hydrolamins also forms a chemical barrier against further irritation.

SUPPLIED: In 1 oz. and 2.5 oz. tubes.



Pharmaceutical Company, Chicago 14, Illinois

 Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pro Am. J. Digest. Dis. 18:59 (Feb.) 1951.

 Fromer, J.L.: Dermatologic Concepts and Management of Pruritus Ani, Am. J. 90:805 (Nov.) 1955.

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brings dependable relief where other drugs fail

# intermittent claudication

urterioscieresia oblitorana recent thrombotic closure thromboanglitis oblitorana effective
in
disbotic vascular disease
Reynand's disease
ischemic ulcers

Stein, I.: Annals of Internal Medicine 45:185, 1956.

Stein\* finds the unique peripheral vaso dilator, Artidin, a "welcome and valuable addition in the treatment of chronic vascular disease," because of these major advantages:

# advantage No. 1

While other drugs improve circulation only in the skin and do little to relieve muscle pain and spasm, Arlidin effectively dilates blood vessels in skeletal muscle—where needed most.

#### advantage No.



While other vasodilators, after their first beneficial effects, have little value in increasing walking tolerance in peripheral vascular disease, Arlidin improves the ability to walk in 2 out of 3 patients for as long as it is administered.

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Arlidin assures "freedom from side or toxic reactions... ease of administration".

TWO FORMS: ARLIDIN HCI tablets ,6 mg. (scored); dosage 1 tablet t.i.d. or q.i.d. bottles of 50, 100 and 1000.

ARLIDIN HCI parenteral 5 mg. per cc.; dosage 0.5 cc. by slow subcutaneous or intramuscular injection; increased gradually to 1 cc. one or more times daily as required.

1 cc. ampuls, boxes of 6, 25 and 100.

10 cc. multiple dose vial, box of 1.

protected by U. S. Patent Nos. 2,661,372 and 2,661,373

Sample supply of Arlidin and reprint on request.

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Pops, like the Doctor said how about real apples



Real apples
coming up, Juniornatural taste,
natural vitamins
in Beech-Nut



TRUST BEECH-NUT...CAREFULEST BABY FEEDERS IN THE WORLD
42 MEDICAL ECONOMICS JUNE 1957

## A simple but neglected diagnostic procedure

Proctosigmoidoscopy is the only accurate method of polyp detection.<sup>1</sup> Yet internists and general practitioners, upon whom diagnosis often depends, continue to neglect it.<sup>1</sup>

Preparation for proctosigmoidoscopy in office or hospital is greatly simplified by the FLEET ENEMA Disposable Unit. Cleansing is thorough yet gentle, permitting a clear field, and more effective than one or two pints of soap suds or tap water.

FLEET ENEMA contains, per 100 cc., 16 Gm. Sodium Biphosphate and 6 Gm. Sodium Phosphate, in a ready-to-use squeeze bottle with self-lubricated, anatomically correct rectal tube.

 Crumpacker, E. L., et al, AMA Arch. Int. Med. 98:314, 1956.
 Swinton, N. W., Surg. Clin. No. Am. 35:833, 1955.

# FLEET ENEMA

Disposable Unit

C. B. Fleet Co., Inc., Lynchburg, Virginia

Makers of Phospho-Soda (Fleet)
A laxative of choice for over 60 years





or.



AGE... In older people, chronic constipation and biliary dyspepsia are often the result of decreased food and water intake, inactivity, intestinal muscle atonicity, increased anorectal disorders, biliary stasis.

# for biliary dyspepsia and constipation

**OCCUPATION** . . . Among the sedentary workers, chronic constipation and impaired digestion are often the result of lack of exercise which retards normal peristaltic action in the gastrointestinal tract.



Tablets of Caroid and Bile Salts with Phenolphthalein are specifically formulated to provide a 3-way, comprehensive approach to the problem of impaired digestion and elimination.

- 1. CHOLERETIC
- 2. DIGESTANT
- 3. LAXATIVE

Bile salts stimulate biliary flow for improved fat emulsification while Caroid steps up protein digestion up to 15%. Gentle stimulant laxatives induce formed, easily passed stools.

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CAROID® AND BILE SALTS Tablets



new high values for frozen citrus

Recent assays by the Wisconsin Alumni Research Foundation<sup>1</sup> reveal frozen citrus juices significantly higher in vitamin C than shown by the latest U.S.D.A. Handbook (No. 8, 1950), with orange juice averaging 20% higher...further proof it is the "nutritive equal" of fresh juice. Recommended Daily Allowanees for vitamin C as provided by frozen citrus juices are shown below.

Reconstituted frozen Reconstituted frozen orange juice grapefruit juice

75 mg.—normal adults	5 fl. oz.	61/2 fl. oz.
100 mg.—late adoles- cence or pregnancy	7 fl. oz.	8½ fl. oz.
30 mg.—infants to 1 year of age	4¼ tablespoonfuls	

Florida Citrus Commission, Lakeland, Florida



1. J. Agr. & Food Chem. 4:418, 1956.

2. A.M.A., Council on Foods & Nutrition: J.A.M.A. 146:35, 1951.

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# Letters

#### **Multiple Insurance**

SIRS: What do you do when a military-dependent patient undergoes elective surgery and has one or two insurance policies in addition to her Medicare coverage?

I've been told the surgeon must accept only the Medicare fee, regardless of the patient's income, and that the patient may pocket any money paid by her commercial policies.

I feel that this sort of thing is an injustice to the surgeon. As far as I can see, he has only two possible "outs":

The first is to refuse to sign any commercial insurance vouchers. This, of course, is all to the advantage of the commercial insurers and certainly not fair to anyone else concerned.

The other is to delay entering the Medicare form until he's been paid out of the patient's commercial insurance benefits. He can then truthfully sign a statement to the effect that he'll accept only what Medicare gives him.

He can then credit the patient's account with any overpayment he receives.

Herbert W. Horne Jr., M.D.
Brookline, Mass.

SIRS: Should the *physician* decide, in a case of multiple coverage, which insurance company should pay less than it contracts for? It seems pretty unrealistic to expect him to police the morals of the carriers concerned.

Leo Price, M.D. New York, N.Y.

SIRS: . . . Here in Rhode Island, we try to prorate the fees among all insurers in each case. But it's not a completely satisfactory solution. I still think there should be one adequate single-coverage plan.

Charles L. Farrell. M.D. Pawtucket, R.I.

Sirs: I'm surprised no one has mentioned that it's the patient who pays for multiple coverage—and often at a fairly high premium. The charge that the patient "profits" from fore, a

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from multiple coverage is, therefore, a little strange.

Apparently the idea has gotten around that some people buy multiple coverage in order to defraud, and that the doctor should charge enough to prevent this.

I disagree. It does not seem at all reasonable to me for the doctor—or anyone else, for that matter—to penalize a patient for having bought more health insurance than someone else.

Emeline Place Hayward, M.D. New York, N.Y.

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Sirs: As a doctor's secretary, I can appreciate Dr. Francis T. Hodges' posthumous article, "Medicine's Seven Deadly Sins." He could have added another sin: some doctors' lack of consideration for their employes.

Even a casual search will turn up many a practitioner who makes a big income but expects his helpers to work for substandard pay. Such a man often requires his aides to work a 44- to 60-hour week, instead of the standard 40 hours. And, more than likely, he resists spending money for decent office equipment, even though he has money for a fine home, a new car, and even a boat.

From the standpoint of his aide, though, the worst thing is his indifferent attitude toward patients. He cancels appointments arbitrarily, often, and on too short notice. When a patient has an urgent problem, he's likely to be incommunicado.

On top of this, such a doctor's fees are generally too high. Yet it's the aide who must collect the bills—and still maintain the patients' goodwill.

How do you explain behavior like this in some physicians when so many others hold true to Hippocratic principles and the golden rule? How can you explain it?

Secretary Miami, Fla.

SIRS: Speaking of doctor's in-

comes (and a medical secretary like me may be forgiven for doing so), I was actually embarrassed when I went to seek help on my income tax.

"What's this?" the accountant said. "Twenty-seven hundred dollars? For the full year 1956? Is that really all you earned?" (The man I work for netted almost exactly that amount in just the first six weeks of 1957.)

As with most aides, I do cardiograms, basals, X-rays, blood tests —plus all the bookkeeping and secretarial work. If I'm lucky—and if I ask for it—I may get a \$5-a-week raise every other year.

The A.M.A. looks after the phy-

sicians—but who looks after the poor aides?

Penniless Aide Baltimore, Md.

#### **Who Gets Referrals**

SIRS: "Why Some Specialists Get More Referrals" prompts me to ask: Doesn't the specialist (and I am one) owe two additional responsibilities?

First, to provide everything necessary in each case, regardless of fee—be this laboratory tests, X-rays, endoscopy, or what not. (There's no more helpless feeling for the family physician than the thought that consultation will probably reveal no serious organic disease, but

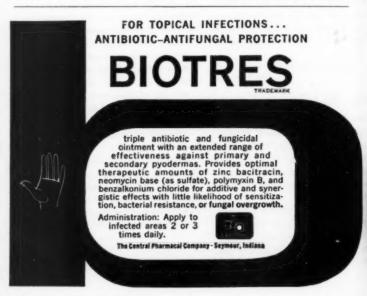
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physiologic...a clinical
counterpart of breast milk
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• avoids excoriated buttocks • minimizes digestive upsets • virtually eliminates hyperirritability due to subclinical tetany • avoids excessive renal solute load, thus lessening the dangers of dehydration should periods of stress occur

natural tranquility

characteristic of babies \* fed

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whenever prenatal examination reveals familial history of allergy (in either parent or a sibling)

**Borden's** 

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... when fed from birth, allergie or potentially allergic infants are usually free from allergic symptoms...and future allergic cripples are avoided.

MULL-SOY ... pioneer hypoallergenic alternative to cow's milk...now even better in palatability, lighter color, freedom from loose stools, in promoting normal growth and development. Easily digested and assimilated, free of added potential allergens, high in unsaturated fatty acids.

a century of infant

MULL-SOY . BREMIL . DRYCO . BETA LACTOSE . KLIM

products of BORDEN'S PRESCRIPTION PRODUCTS DIVISION, 350 Madison Ave., New York II \*A comprehensive bibliography on cow's milk allergy is available to interested physicians

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... Relieve

4. simple, 5. low cost

## TREAT HER MORNING SICKNESS...THE NIGHT BEFORE



... In 200 cases, effective in all but one.1

Long-acting Bendectin, new anti-emetic, unusually effective in prevention of nausea and vomiting of pregnancy. Bendectin gives your patient the benefit of three distinct and complementary modes of action:

- 1. antispasmedic relaxes G.I. smooth-muscle spasm
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- 1 nutritional supplementation to overcome possible pyridoxine deficiency of pregnancy

... Relieves morning sickness "before it starts"

Other advantages include: 4 simple, convenient bedtime dosage

8. low cost to patient

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Age: 42 Patient: H. D. History: "She complained, matter how much I sleep, I'm never rested...It is more than weakness, Doctor. I feel so weak I'm afraid to walk downstairs. Examination and lab tests only confirmed what I had suspected from her voice, her breathing, her weary eyes: psychogenic fatigue."

Treatment: 'Dexamyl'

Results: "With 'Dexamyl' she became surprised at her own potentialities. She astonished her husband by being cooperative and helpful. The drug raised her nervous threshold: she became more confident and optimistic. Tension relieved, she soon regained a normal sleep pattern and felt rested enough to perform her daily tasks."

(From a case history by the patient's physician; unposed photos taken during an office visit..)

# In psychogenic fatigue

Dexamyl' a balanced combination of two "Dexamyl"—a balanced communation of the following affairs affairs affairs which is from affairs affair thour-amenorating components—provides the shifting agents associations affect which is free of the dulling effects sometimes caused by anti-anxiety, agents alone; free of the excitation sometimes caused by stimulants

DEXAMYL \* / tablets - ctixir - Spansulet capsules Smoothly and subtly relieves both depression and anxiety Smith, Kline & French Laboratories, Philadelphia

F. M. Roy, U.S. Pat. Off.

anatomico, U.S. Pat. Off.

anatomico, Capacito, S. K. F.

will certainly be more costly than the family can afford.)

Second, to be firmly considerate in remembering the patient's responsibility to his own doctor. (Recently a fellow physician and friend asked me to continue with a patient he'd referred to me. Only by chance did I discover later that fee payment via insurance coverage had already been sent to my office. But my friend, the family physician, was still waiting for his money.)

Warren C. Breidenbach, M.D. San Francisco, Calif.

#### **Doctors on Salary**

SIRS: An unnamed medical school dean was quoted in your article "Why More Doctors Are Going On Salary." He said hospitals would win any open fight over whether doctors will work for hospitals on salaries.

Let this dean stand up and make himself known. He apparently feels that doctors must surrender to the salaried system because hospitals "represent more people" than physicians do. I am sure all these "people" would be interested in learning whether the eventual aim is to have all doctors on salary. After all, the hospitals would undoubtedly profit by such an arrangement. But there's some question about the caliber of the physicians it would be likely to attract.

It is regrettable that the dean

spacks of winning and losing, as though this were a war between hospitals and doctors. But if war it's to be, the participants should be identified for all to know. The "people," who evidently are to be the judges, have just seen the result of regimentation of doctors in Britain.

Robert R. Cross, M.D. Chevy Chase, Md.

SIRS: I have to disagree with the statement that once "the incentive of fee-for-service practice is gone, more doctors will practice mediocre medicine."

This implies (1) that doctors practice good medicine for none but financial reasons, and (2) that all salaried doctors would receive the same stipend.

Although now on a salary myself, I spend ten to sixteen hourn daily on a job that demands only eight. The fact is: Salary differentials can offer as much incentive as fees-for-service.

> Jerry Ramunis Capt., U.S.A.F. (M.C.) Hill Air Force Base, Utah

### Staff Speakers Only?

SIRS: Dr. Kenneth B. Babcock's statement in MEDICAL ECONOMICS that the Joint Commission on Hospital Accreditation did not want outsiders giving papers at staff meetings, but wanted staff members to learn from the composite experience of their colleagues, re-

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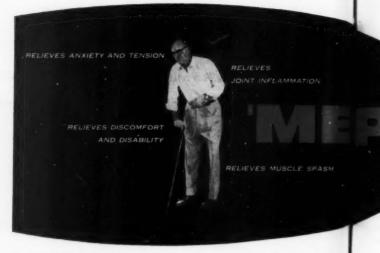
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Each Multiple Compressed Tablet of MEPROLONE provides the inseparable antiarthritic, antirheumatic benefits of:

 Prednisolone buffered—the newest and most potent of the "predni-steroids" for prompt relief of joint pain and arrest of the destructive inflammatory process.

Meprobamate—the newest and saf-est of the muscle-relaxant tranquilizers for profound relaxation of skeletal muscle in spasm.

Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation mea-

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: a) inflammation b) muscle spasm c) anxiety and tension d) discomfort and disability; i.e., rheumatoid

Therapeutic benefits of MEPROLONE ared with traditional antiarthrities

	relieves pain	suppresses inflam- mation	relaxes muscle	eases anxiety	1000 to 1000 t
Salicylates	1	1			
Muscle relaxants			1		
Tranquilizers				1	
Steroids	1	1			4
MEPROLONE	1	1	1	1	4

1. Meprobamate is the only trans iner with muscle-relaxant act

arthritis, rheumatoid spondylitis (Marie-Strin pell disease), Still's disease, psoriatic arthriti osteoarthritis, bursitis, synovitis, tenosynoviti osteoarthrits, burstis, synovitis, tenosynous myositis, fibrositis, fibromyositis, neuritis, acid and chronic low back pain, acute and chrosiprimary and secondary fibrositis and torticolis intractable asthma, respiratory allergies, allergiand inflammatory eye and skin disorder file maintenance therapy in disseminated lupus try thematosus, periarteritis nodosa, dermatomy tis and scleroderma).

SUPPLIED: Multiple Compressed Tables bottles of 100 in two formulas as follows: Msrp-LONE-1—1.0 mg. of prednisolone, 200 mg. 6 meprobamate and 200 mg. of dried aluminos hydroxide gel. Msrpatonst-2—provides 2.0 m of prednisolone in the same formula. NO OTHER

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MEPRO BAMATE
PREDNISO LONE, buffered

THE ONLY

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ANTIARTHRITIC

THAT SIMULTANEOUSLY

RELIEVES:

- 1. MUSCLE SPASM
- 2. JOINT INFLAMMATION
- 3. ANXIETY AND TENSION
- 4. DISCOMFORT

  AND DISABILITY



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vealed exactly what many critics have been fearing: that requirements are being formulated by medical theoreticians unfamiliar with some of the subjects that they rule on.

Staff members would have very little confidence in the composite experience of their competitors, who would be bound to use the same authorities and references that outsiders use. Local speakers would lack medical authority in the fields selected. Audiences would appear to listen only because attendance was compulsory.

A physician's time is too valuable to be wasted on staff programs dictated by agencies not qualified in the field of post-graduate medical education.

> R. H. Sherwood, M.D. Niagara Falls, N.Y.

#### Post-graduate Study

SIRS: You may be interested in a comment I sent to the Pennsylvania Academy of General Practice in response to a questionnaire on required post-graduate study for membership:

"To constantly present to the public the impression that general practitioners are in need of post-graduate study and that unless they obtain this study they are not good general practitioners, is to defeat our own purpose.



replacement for cow's or goat's milk since it closely approximates evaporated milk in complete proteins, carbohydrates, fats, minerals—is well-tolerated by even the newborn.

Clinical survey\* indicated no weight loss or anemia in over 100 infants receiving meat base formula.

To be fed through regular nursing bottles.

Available through druggists on specification.

Gerber Products Company, Fremont, Mich.

\*Rowe, Albert, Jr. and Rowe, Albert H .: Cal. Med. 81:279 (Oct.) 1954

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that patient may need nutritional support that patient may need a corrected diet and

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Thiamine	10 mg.
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ia in eor ne al stey "General practitioners can best serve by active participation on hospital staff committees, and in county, state, and national medical societies.

"This is the thing that will bring a renaissance of the general practitioner, and not the demand (which is an indignity) that he take postgraduate study."

Arthur J. Ricker, M.D.
Secretary-Treasurer
Bucks County Academy of General Practice
New Hope, Pa.

#### 'English Murder' Case

SIRS: The July 1956 issue of The Maryland State Medical Journal carried an article of mine: "Have We Reached the End of the Cultural Period in Medicine?" The News columns of your October 1956 issue included a few small excerpts titled "M.D.s Said to 'Murder the King's English.'"

Recently, in your Letters columns, three correspondents have criticized the excerpts. Such criticism is, in my view, as indefensible as it would be for a judge to pass sentence after hearing only part of the testimony. But here is my comment on the points raised:

¶ The correct pronunciation of a word is not got from dictionaries, but from the etymology of the word. "Syndrome" is correctly pronounced in three syllables. If one is going to abuse the Greek, he may as well say "systole" in two syllables, too. ¶ The correspondent who accuses me of pedantry probably does not know the meaning of the word. "Clarity and forthrightness are more important than strict accuracy," he declares. Yet how can one be clear or forthright without being strictly accurate?

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¶ The claim that "patients now need Latin and Greek far less than they need effective therapy" leads me to quote Osler:

"In no profession does culture count for so much as in medicine. and no man needs it more than the general practitioner, working among all sorts and conditions of men, many of whom are influenced quite as much by his general ability, which they can appreciate, as by his learning, of which they have no measure. The wider and freer a man's general education, the better practitioner he is likely to be-particularly among the higher classes, to whom the reassurance and sympathy of a cultivated gentleman of the type of Eryximachus may mean much more than pills and potions."

Some of our best medical schools are becoming greatly concerned by the lack of a knowledge of the humanities in the students, fresh from college, just entering medical school. My article was an attempt to bring this to the attention of the profession.

Amos R. Koontz, M.D. Baltimore, Md. END

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- Peptic ulcer

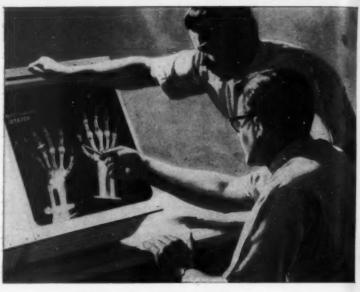
For the hyperacidity that is so common on the American scene, ALUDROX gives acid-hungry therapeutic action without systemic penalties. ALUDROX combines reactive alumina gel with nilk of magnesia in a rational proportion of 4.1. It is a balanced formula for prompt relief, soothing action, and healing powers—without constipation, acid rebound, or alkalosis.



Aluminum Hydroxide with Magnesium Hydroxide to neutralize, not penalize



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# in arthritis, BUFFERIN® because ...

...in the majority of your arthritic cases Bufferin alone can safely and effectively provide adequate therapeutic control without resorting to the more dangerous cortisone-like drugs.

...Bufferin is better tolerated by the stomach than aspirin, especially among arthritics where a high dosage, long term salicylate regimen is indicated.

...Bufferin provides more rapid and more uniform absorption of salicylate than enteric-coated aspirin.

...even in the relatively few cases where steroids are necessary, use of Bufferin will allow proper flexibility for individual dosages.

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...Bufferin contains no sodium, thus massive doses can be safely given without fear of sodium accumulation or edema.

Each sodium-free BUFFERIN tablet contains acetylsalicylic acid
5 grains, and the antacids magnesium carbonate and aluminum glycinate.

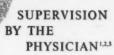
Bristol-Myers Company, 19 West 50 Street, New York 20, New York

60 MEDICAL ECONOMICS - JUNE 1957

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Three essential steps in establishing correct eating patterns:



A BALANCED EATING PLAN<sup>1,2,3</sup> In the development and maintenance of good eating habits, there are three essentials: support and supervision by the physician, a balanced eating plan, and selective medication, 1.3.4

SELECTIVE MEDICATION<sup>1,2,3</sup>

OBEDRIN PROVIDES:

- · Methamphetamine for its anorexigenic and mood-lifting effects.
- · Pentobarbital as a balancing agent, to guard against excitation.
- Vitamins B, and B2 plus niacin to supplement the diet.
- · Ascorbic acid to aid in the mobilization of tissue fluids.

Since Obedrin contains no artificial bulk, the hazards of impaction are avoided. The 60-10-70 Basic Plan provides for a balanced food intake, with sufficient protein and roughage.

- 1. Eisfelder, H.W.: Am. Pract. & Dig. Treat. 5:778 (Oct. 1954).
- 2. Freed, S.C.: G.P. 7:63 (1953).
- 3. Sherman, R.J.: Medical Times, 82:107 (Feb. 1954).

# Obedrin

#### FORMULA:

Semoxydrine HCl (Methamphetamine HCl) 5 mg.; Pentobarbital 20 mg.; Ascorbic acid 100 mg.; Thiamine mononitrate 0.5 mg.; Riboflavin 1 mg.; Niacin 5 mg.

Write for 60-10-70 Menu pads, weight charts and clinical supply of Obedrin.

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allays anxiety and tension without depression, drowsiness, motor incoordination

NOSTYN is a calmative—not a hypnotic-sedative—unrelated to any available chemopsychotherapeutic agent • no evidence of cumulation or habituation • does not increase gastric acidity or motility • unusually wide margin of safety—no significant side effects

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supplied: 300 mg. scored tablets, bottles of 48 and 500.

\*Ferguson, J. T., and Linn, F. V. Z.: Antibiotic Med. & Clin. Therapy 3:329, 1956.

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For infected, or potentially infected, inflammatory conditions of the eye (anterior segment), ear and skin

VIRTUALLY NON-SENSITIZING

Jach Gm. contains: 'Aerosporin'® Sulfate Polymyxin B Sulfate 5.000 Units; acitracin 400 Units; Neomycin Sulfate 5 mg.; hydrocortisone (free alcohol) 10 mg. (1%).

Available in applicator tip tubes of 1/2 oz. and 1/2 oz.

Each cc. contains: 'Aerosporin'® Sulfate Polymyxin B Sulfate 10,000 Units; Seomycin Sulfate 5 mg.; Hydrocortisone (free alcohol) 10 mg. (1%). stailable in sterile dropper bottles of 5 cc.

RROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

MEDICAL ECONOMICS - JUNE 1957 63

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# New, low-cost copy maker saves time in billing



# Exclusive dry process is All-Electric... prepares itemized statements in 4 seconds

This amazing new THERMO-FAX "Secretary" Copying Machine can copy your office account cards in 4 seconds for as little as 2¢ per copy. The copy you make becomes a patient's itemized statement. You save time, end billing questions and errors. New machine is All-Electric, eliminates chemicals and special installations. Send the coupon today for full details on the new, lower-cost way to save time in your billing.

\*Suggested retail price.





The terms THERMO-FAX and SECRETARY are trademarks of Minnesota Mining & Mig.Co., St. Paul 6, Minn. General Export: 99 Park Avenue, New York 16, N. Y. In Canada: P. O. Box 757, London, Ontario.

Minnesota Mining & Mc Dept. KX-67, St. Paul (	
Send details on the new	All-Electric THERMO-FAX Copying Machine.
Name	
Name	

4 MEDICAL ECONOMICS - JUNE 1957

puts hay fever patients back in the picture



stand-out relief, all day without interruption

CHLOR-TRIMETON REPETABS

Schering

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rade-Winn. N. Y.



she's back in the picture...

4 mg



with the full dimensions of relief

# CHLOR-TRIMETON REPETABS stand-out hay fever relief set to repeat all day-

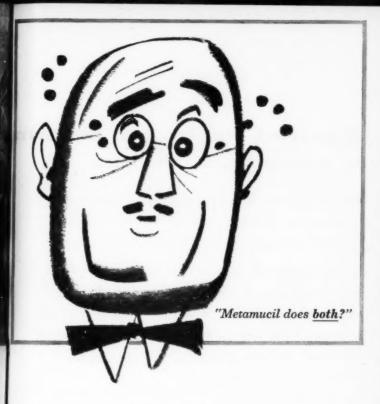
—enables the patient to take one CHLOR-TRIMETON REPETAB upon arising and give no thought to further medication until retiring. Immediate relief through rapid attainment of therapeutic levels is maintained all day or all night without the "relapses" common to conventional dosage forms. Moreover, CHLOR-TRIMETON is remarkably devoid of sedative effects and thus assures hay fever patients a sense of well-being comparable to that enjoyed by nonallergic individuals.

Also available—CHLOR-TRIMETON Tablets, 4 mg. (secred) and CHLOR-TRIMETON Syrup, 2 mg. per temapoonful.

CHLOR-TREMITOR® Maleate, brand of Chlorprophenpyridamine Maleate U.S.P. REPETARS, © Repeat Action Tablets.

Schering

CTN-J-54



Metamucil does both: the demulcent mucilloid produces soft, easy stools and stimulates normal peristalsis. This is "smoothage" management of constipation without the use of irritant laxatives.

# METAMUCIL SEARLE

psyllium hydrophilic mucilloid with dextrose

MEDICAL ECONOMICS · JUNE 1957 67

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# Against Pathogen & Pain

in urinary tract infections

Azo Gantrisin combines the single, soluble sulfonamide, Gantrisin, with a time-tested urinary analysis - in a single tablet.

Prompt relief of pain and other discomfort is provided together with the wide-spectrum antibacterial effectiveness of Gantrisin which achieves both high <u>urinary</u> and <u>plasma</u> levels so important in both <u>ascending</u> and <u>descending</u> urinary tract infections.

Each Azo Gantrisin tablet contains 0.5 Cm Gantrisin 'Roche' plus 50 mg phenylazo-diamino-pyridine HCl. Gantrisin® - brand of sulfisoxazole



Original Research in Medicine and Chemistry



vitamin protection the baby needs

Tri-Vi-Sol®

asic vitamins...A, D, C

Poly-Vi-Sol®

6 essential vitamins ... A, D, C, B,, B<sub>a</sub> and niacinamide

Deca-Vi-Sol®

10 nutritionally significant vitamins, including A, D, C, B, Ba, niacinamide, biotin, pantothenic acid, B4 and stable Bis



istry

· highly stable - refrigeration not required

· readily accepted - exceptionally pleasant flavor, no unpleasant aftertaste

· full dosage assured - can be dropped directly into baby's mouth

In 15 cc., 30 cc. and economical 50 cc. bottles with calibrated plastic 'Safti-Dropper'

MEAD JOHNSON

MEDICAL ECONOMICS JUNE 1957 69



"Heavy? Don't be silly, Aunt Phoebe! What's hard about carrying lightweight E & J chairs?"



ES

E & J Power Drive Chair runs, turns, steers with one-knob control E & J chairs are lightweight — yet no wheel chair on the market is stronger or has better balance.

E & J's modern good looks and effortless handling overcome "wheel chair shyness" and invite activity.

For patients young or old, you can recommend an E & J with confidence.

There's a helpful E & J Dealer near you

EVEREST & JENNINGS, INC. LOS ANGELES 25

70 MEDICAL ECONOMICS · JUNE 1957

Many appet stimu

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Now

Each



for your below-par patients

# **TROPH-IRON\***

B12-Iron-B1

Many adult patients who are finicky eaters find their appetites improved by "Troph-Iron" therapy. In addition to stimulating appetite in these patients, "Troph-Iron" corrects the nutritional iron deficiency that often accompanies poor eating habits.

'Troph-Iron' is also an ideal nutritional adjunct for below-par children.

### Now in 2 forms:

- 1. Delicious cherry-flavored liquid for children
- 2. Tablets for older patients

Each 5 cc. teaspoonful of liquid (or each tablet) contains:

 Vitamin B<sub>12</sub>
 25 mcg

 Vitamin B<sub>1</sub>
 10 mg

 Ferric pyrophosphate
 250 mg

to stimulate appetite • to promote growth to correct nutritional iron deficiency

Smith, Kline & French Laboratories, Philadelphia

\*T.M. Reg. U.S. Pat. Off.

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LES 25

RIES



# Trasentine-Phenobarbital

C I B A Summit, N. J.

2/323816

integrated relief... mild sedation visceral spasmolysis mucosal analgesia TABLETS (yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.

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FOR C

IN A

Medil U.S. aero 0.12 mea

# MILLIONS OF ASTHMATIC ATTACKS

have been aborted faster...more effectively... more economically with



SIMPLE TO USE



CONVENIENT



FOR CHILDREN, TOO

CIBA)



SLIPS INTO POCKET OR PURSE

Automatically measured dosage and true nebulization...nothing to pour or measure...One inhalation usually gives prompt relief of acute or recurring asthmatic attacks.

Medihaler-Epi replaces injected epinephrine in urticaria, edema of glottis, etc. due to acute food, drug, or pollen reactions...

> Each 10 cc. bottle delivers 200 inhalations.

### IN ASTHMA PRESCRIBE EITHER -

Medihaler-EPI Riker brand epinephrine U.S.P. 0.5% solution in inert, nontoxic aerosol vehicle. Each measured dose 0.12 mg. epinephrine. In 10 cc. bottle with measured-dose valve.

Medihaler-ISO Riker brand isoproterenol HCI 0.25% solution in inert, nontoxic aerosol vehicle. Each measured dose 0.06 mg. isoproterenol. In 10 cc. bottle with measured-dose valve.

Note: First prescription for Medihaler medications should include the desired medication and Medihaler Oral Adapter (supplied with pocket-sized plastic carrying case for medication and Adapter).

The Medihaler Principle

is also available in Medihaler-Nitro™ (octyl nitrite) for the rapid relief of angina pectoris...and Medihaler-Phen [Medihaler-Phen] (phenylephrine-hydrocortisone-neomycin) for lasting, effective relief of nasal congestion.

MEDICAL ECONOMICS - JUNE 1957 73



NEW

# PACA

74 MEDICAL ECONOMICS - JUNE 1957

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#### TO "NORMALIZE" THE THINKING PROCESSES\*

AN ADVANCE: A superior, new phrenotropic agent, Pacatal represents an important advance in the treatment of mental and emotional disorders. This new phenothiazine derivative has a tranquilizing action, but overcomes many of the disadvantages inherent in treatment with the earlier phenothiazine compounds.

TRANQUIL. YET RESPONSIVE: With Pacatal, the physician now has an agent which exerts a calming influence, but does not "flatten" the patient. Following treatment with Pacatal, patients are calmed, yet they remain alert, active and cooperative.

FEWER SIDE EFFECTS: Pacatal also has fewer side effects at recommended dosage levels. Atropine-like effects may occur in some patients, but tend to disappear with continued therapy. Occasional troublesome cases are usually controlled with oral doses of neostig-

DOSAGE: Usual dosage for the ambulant patient is 25 mg. 3 or 4 times daily; for the hospitalized patient, 50 mg. 3 or 4 times daily. Complete literature and dosage instructions (available on request) should be consulted.

SUPPLIED: 25 and 50 mg. tablets in bottles of 100 and 500. Also available in 2 cc. ampuls (25 mg./cc.) for parenteral use.

\*Many investigators report that Pacatal seems to have a "normalizing" action, i.e., patients appear to think and respond emotionally in a more normal manner.

#### WARNER-CHILCOTT

100 YEARS OF SERVICE TO THE MEDICAL PROFESSION



RAND OF MEPAZINE



"... Well, I always prescribe Rorer's Maalox. It's an excellent antacid, doesn't constipate and patients will take it indefinitely."

MAALOX® suspension, bottles of 12 fluidounces (sample on request); tablets, bottles of 100.

An efficient antacid suspension of magnesium-aluminum hydroxide gel; tablets, 0.4 Gm.

WILLIAM H. RORER, INC. 4865 Stenton Ave., Philadelphia 44, Pennsylvania

76 MEDICAL ECONOMICS - JUNE 1957

Litera

# Why are PERCODAN° Tablets better for pain?

SPEED OF ACTION	WITHIN 5-15 MINUTES1-3	1
DURATION OF EFFECT	6 HOURS AND LONGER <sup>1-9</sup>	1
THOROUGHNESS OF PAIN RELIEF	USUALLY COMPLETE <sup>1-8</sup>	<
INCIDENCE OF CONSTIPATION	RARE <sup>1-3</sup>	1

almost immediate relief of pain

sleep uninterrupted by pain

reliability of pain relief

excellent for chronic and bedridden patients

# Better than codeine plus APC"

Average adult dose: 1 Percodan\* Tablet every 6 hours.

Supplied: Scored, yellow oral tablets, containing salts of dihydrohydroxycodeinone and homatropine, plus APC. May be habit-forming. Percodan Tablets are available at all pharmacies.

References: 1. Piper, C. E., and Nicklas, F. W.: Indust. Med. 23:510, 1954. 2. Blank, F., and Boas, H.: Ann. West. Med. & Surg. 6:376, 1952. 3. Chasko, W. J.: J. District of Columbia Dent. Soc. 31:3, Ne. 5, 1956. 4. Cass, L. J., and Frederick, W. S.: M. Times 34:1318, 1956. 5. Boaica, J. J.: GP 10:35, No. 5, 1954.

Literature? write



ENDO LABORATORIES, Richmond Hill 18, New York

\*U.S. Pat. 2,628,185

100. lm.

nia

# THE PICTURE OF COMFORT. ALL THROUGH THE PREGNANCY

she's blue at breakfast.

# stops morning sickness

Controlled studies indicate that DONADOXIN relieves symptomsquickly-in 9 of every 10 gravida. Tolerance is excellent.

Prescribe: One tablet at bedtime. Severe cases, one tablet at bedtime, one on arting, in tiny pink-and-blue tablets, bottles of 25 and 100. R only.

> if she needs a nutritional buildup-and freedom from leg cramps†

prescribe STORCAV

Phosphate-free calcium, iron, 10 essential vitamins, 8 important in nerals.

Usually 3 tablets daily, with meals In bottles of 100.

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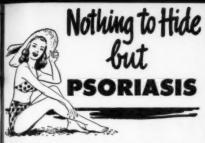
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RIASOL has made many an embarrassed woman proud to wear a revealing bathing sait. By clearing the ugly patches of psorisis, it leaves a normal healthy skin for admiring eyes.

It is well known that exposure to abundant sunlight at the beaches is beneficial in portasis. Few patients, however, will expose themselves to curious and critical eyes mill the skin patches have been controlled with RIASOL.

RIASOL acts best when the treated parts are also exposed to direct sunlight. For this reason it is advisable to treat all cases of psoriasis intensively during the summer months.

Medical statistics show that favorable realts are obtained in approximately 76% of all cases of psoriasis treated with RIASOL.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and horough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.

### Test RIASOL Yourself



MAY WE SEND you professional literature and generous clinical package of RIASOL. No obligation. Write

SHIELD LABORATORIES
Dept. ME-657

12850 Mansfield Avenue Detroit 27, Michigan



BEFORE USE OF RIASOL



AFTER USE OF RIASOL

RIASOL FOR PSORIASIS

# Views

## Why People Borrow

When a man seeks a loan, he's generally asked, "What do you want it for?" The point of the question is of course whether the money loaned will be used for a deserving purpose.

Most people aren't slow to catch on to this. So few of them say, "I want the dough to put on Rubberlegs in the fifth at Pimlico today" or "I want it so I can buy a second TV set."

Instead, they cast about for a nice, respectable reason; and it often turns out to be: "So I can pay off my medical bills."

Thus, the doctor finds himself billed again as one of the Legrees who are hounding people toward the poorhouse.

Most recent evidence of the public's predilection for "medical bills" as an excuse to borrow money comes from a survey among 1,800 member firms of the National Consumer Finance Association. It shows that people who say they borrow to pay medical bills are half again as numerous as those who borrow to buy cars and several times more numerous than those who admit they are borrowing to buy less essential items.

Wouldn't it be nice if doctors actually saw the color of all this money that patients borrow in their behalf? It must amount to a fair proportion of the \$500,000,000 annually they bill for but never collect.

### Mail Call

When do you read your mail? From some doctors, the truth would be, "Whenever I get around to it."

Such a man may look pretty foolish if he visits a patient's home and she alludes cryptically to a set of new symptoms detailed in a letter still lying unopened on his desk, Even more foolish if she wrote her letter to cancel the visit.

Just five minutes spent on your mail first thing every morning will usually give you its high points. Bette aide, stack of pr

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Better still, if you have a capable aide, let her sift the mail for you, stacking and marking it in order of priority.

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Suppose someone asked you to name the most important type of insurance for a private practitioner. Would you say "Life insurance"?

If so, it may surprise you to learn that a number of insurance counselors think otherwise. More essential than life insurance, in their view, is protection against disablement due to ill health or an accident.

Look at it this way: When the breadwinner dies, his family needs money for its support. When he's disabled, his family needs more money not only for its support but also for his. In terms of hard cash, then, long-term disability can pose a greater threat than sudden death.

Most working men nowadays get a limited form of disability protection from the moment they first

punch a time-clock. But professional men, largely untouched by compensation laws or by employe benefit plans, must shift for themselves.

Health and accident insurance, if carefully chosen, can fill the bill. One often-recommended combination of policies will pay you disability benefits of \$700 a month for more than nine years. Total cost of these policies, if taken out at age 40: around \$560 a year.

Steep? Maybe so. But think of the alternative: What would happen if an accident tomorrow laid you up for six months? Or if a disabling illness forced you out of practice for two years? Think in these terms and you can see why disability income may be just as important as death benefits.

### Delayed Exposure

An apparently well-qualified surgeon was invited to join a group practice in a Midwestern city. Soon thereafter the group's senior, re-



"Dramamine nevertheless proved more effective than other methods hitherto employed in the concededly difficult management of nausea and vomiting of pregnancy."

Cartwright, E. W.: Dramamine in Nausea and Vomiting of Pregnancy, West. J. Surg. 59:216 (May) 1951.

# **Dramamine**<sup>\*</sup>

Brand of Dimenhydrinate

SEARLE

#### VIEWS

turning to the office late one night, caught his new colleague performing an illegal abortion.

What should he have done? Kicked him out of the group? Well, he did that as a matter of course. But that's all he did.

"I couldn't expose him without ruining myself," reasoned the older man. "Then, too, there was the patient to consider."

What the senior doctor forgot were the other patients the dismissed doctor would be doing surgery on after leaving the group. The fact is, there were many—two of whom died as the result of wholly unnecessary operations.

Before long, of course, the man was suspended from hospital practice. But the lesson remains to plague every doctor in that city.

## **Ten-Cent Bargain**

Some of us assume, where patients are concerned, that no news is good news. But is it always? Is that convalescing patient really getting along all right?

The value of a brief phone call in such cases is sure-fire. It gives the patient a real lift. It comes as welcome, fresh proof, too, of the doctor's interest in him.

Here's how one physician we know handles the mechanics:

Whenever he renders a major service that may not require a return visit, he jots the patient's name on his calendar for, say, a week later. When he winds up a series 14

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If he can n erly.

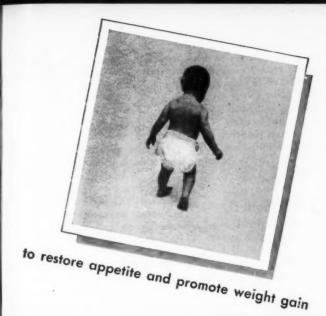
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# rofo:

L-lysine + vitamins + minerals

this baby needs help

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If he turns his back on food, the infant can neither gain weight nor grow properly.

Efficient protein synthesis requires all the essential amino acids, simultaneously, in the correct proportions.

But many foods in the infant diet are relatively deficient in lysine, compared with meat protein.

Supplied: In 46 Gm. bottles with special Lactofort measuring spoon enclosed.

Persistent anorexia calls for nutritional support with Lactofort

This complete nutritional supplement helps to restore normal growth and perk up lazy appetites in infants with anorexia and impaired nutrition. It supplies physiologic amounts of L-lysine to raise the biological value of milk and cereal to that of high-quality animal protein. In addition, Lactofort provides generous amounts of iron, calcium and all the essential vitamins.

Reference: Williamson, M. B., in Albanese, A. A., et al.: New York State J. Med. 55:3453, 1955.

a dry powder . . . stable . . . odorless . . . tasteless . . . readily soluble

first with lysine



WHITE LABORATORIES, INC. . Kenilworth, New Jersey

MEDICAL ECONOMICS · JUNE 1957 83

of treatments or concludes his follow-up care after an operation, he makes a similar note. Then, when the patient's name comes up, he spends three to five minutes on the phone. Mostly just listening.

In these days of sometimes undernourished doctor-patient relations, it would be hard to get more value for a dime.

### Voice With a Smile?

Have you checked up on your telephone-answering service lately?

Several doctors we know do this periodically. And in a small but disturbing percentage of cases, they find that the answering service has responded brusquely, or garbled the message, or failed to get names and numbers right. In one instance, believe it or not, all the answering "voice" would say was: "Sorry. I don't know where the doctor can be reached now."

It might surprise some practitioners to learn that many people confuse the answering service with the doctor's own office—and on their next visit sometimes take a thoroughly pleasant (and quite innocent) aide to task for "your" curtness or failure to be of more help.

Obviously, poor answering service is more than a waste of money: It's a sharp blow to the doctor's



# however YOU see the constipated patient

tied up in knots, or otherwise...

# zilatone

provide judicious, gentle therapy for constipation and associated discomfort

ZILATONE is a rational combination of bile salts to promote secretion of the physiologic laxative, bile; mild intestinal stimulants to assure intestinal activity without griping or overstimulation; and digestants to relieve associated dyspepsia.

Available: in boxes of 20, 40 and 80 tablets, each tablet sealed in sanitary tape.

Samples available to physicians on request.

Drew Pharmacai Co., Inc. 1450 Broadway, New York 18

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# Relief

comes quickly for itching, burning, scaling scalps . . .

Why is Selsun the most effective treatment known for seborrheic dermatitis of the scalp?

Selsun relieves itching, burning symptoms with the first few applications.

Then, Selsun completely controls scaling—in 81-87% of seborrheic dermatitis, 92-95% of dandruff cases.

And relief lasts up to four weeks between applications, with few remissions when Selsun therapy is continued as needed. Selsun is sold in 4-fluidounce bottles with directions, on prescription only.

once you prescribe Selsun

\*Selsun-Selenium Sulfide, Abbott

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# Placidyl (ETHCHLORVYNOL ABBOTT) Sh-hh...

# NUDGES YOUR PATIENT TO SLEEP

Use Placidyl to relieve simple insomnia without need of barbiturates. You'll find it especially desirable for helping patients sleep during periods of worry, mild excitement, domestic or business strain, and the like. Excellent, too, for daytime tranquilizing and muscle relaxation.

100-mg., 200-mg., and 500-mg. capsules, bottles of 100.



To help your patients break 200...

Rx

# BIPHETAMINE

APPETITE CONTROL for 10-14 hours, due to 'Strasionic'—sustained ionic—release.

# PATIENT APPRECIATION

one capsule once-a-day.

# PREDICTABLE

weight Loss Rx Biphetamine capsules containing a mixture of equal parts of amphetamine and dextro amphetamine in the form of a resin complex. Three strengths—Biphetamine 20 mg., 12½ mg., 7½ mg.



For Literature and Samples, Write

Strasenburgh

Rochester, N. Y.



# ECZEMA Coal Tar Therapy without its many disadvantages

All the therapeutic advantages of coal tar for eczema and similar dermatoses are retained in SUPERTAH (Nason's) without black coal tar's odor and repulsive appearance.

SUPERTAH (Nason's), a white creamy ointment of crude coal tar, has these advantages:

Does not burn or irritate the skin\*. Does not stain linen, clothing or skin. Does not have to be removed before each fresh application.

DOES everything crude coal tar ointment will do.

\*Swartz & Reilly, "Diagnosis and Treatment of Skin Diseases," page 66 TAILBY-NASON COMPANY

Kendall Sq. Station, Boston 42, Mass.

#### SUPERTAN (NASON'S)

At leading prescription druggists 2-oz. jars. (5% & 10% strength)



reputation with his patients. Better try calling yourself occasionally from outside the office and see what kind of response you get.

### All Is Not Gold . . .

A Philadelphia doctor, trying to decide what fee to charge for an emergency house call, spied a TV set in the patient's living room.

"Nice-looking set," he said.

"We've got a better one upstairs," the patient boasted.

Result: the doctor doubled the figure he'd had in mind.

This, we submit, is a good example of why the sliding scale of fees has fallen into disrepute. Ever count the TV antennae atop the shanties along any railroad track?

Unless doctors can scale their fees on some much sounder basis, we think they're better off pot to scale them at all.

### Free Rx Blanks

Some otherwise astute physicians seem to have a blind spot for what's on the backs of their free prescription blanks. We're talking about the rather frequently seen imprint:

TAKE THIS TO DUNGELHEIMER'S DRUG STORE 44 N. MAIN ST. **PHONE OL 2-6000** 

Both physician and pharmacist may know, in a particular case, that no harm is done by this modest exchange of benefits. But the paN

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# NO therapeutic roller coaster

Ordinary desiccated thyroid and thyroid fractions have one thing in common: they sometimes produce a highly uneven calorigenic effect. Ordinary thyroid may drop the patient from a "high" of nervousness and tachycardia to a "low" of clinical ineffectiveness. And thyroid fractions tend to cause a far too rapid rise in the metabolic rate (with a consequent risk of cardiac involvement or other complications) followed by a sudden and marked relapse and distressing withdrawal symptoms.1,2

neither too much nor too little: Since it is highly purified and rigidly standardized, Proloid avoids not only the discomfort and danger of too

much response, but also the disappointment of too little. At the same time, Proloid offers the complete thyroid complex, thus assuring the benefits of all the thyroid principles.

smooth, predictable clinical response: Proloid gives the physician close control over therapy, permitting him to achieve the desired results tablet after tablet, bottle after bottle. Today, as through the years, Proloid is preferred whenever thyroid therapy is indicated.

Daily dose: Same as for ordinary thyroid.

References: 1. Beierwaltes, W. H.: J. Michigan M. Soc. 55:180 (Feb.) 1956, 2. Frawley, T. F.; McClintock, J. C.; Beebe, R. T., and Marthy, G. L.: J.A.M.A. 160:646 (Feb. 25) 1956.

the total thyroid complex

RNER-CHILCOTT

100 YEARS OF SERVICE TO THE MEDICAL PROFESSION

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nacist , that odest e patient may not know it. Today, with so much being said in print about rebating, the matter deserves a sober second thought.

Sure, it's nice to have some druggist give you free prescription blanks. But is it worth having even one patient say, "What do you figure the doc's cut is?"

### Heaven Can Wait

What would you do if you were a patient and the doctor kept you waiting a couple of hours past your appointment time?

In case the answer eludes you, we'll repeat an incident that occurred in Detroit. Secretaries in several medical offices there customarily affix the following sticker to outgoing bills that are three months or more past due:

YOUR REQUEST FOR CREDIT WAS NOT IGNORED; THIS REQUEST FOR PAYMENT SHOULD NOT BE

A delinquent debtor who received this notice answered it as follows:

"No, my request for credit wasn't ignored. But some of my 3 o'clock appointments sure as hell were ignored—until 4:30 or 5. So if I can wait, I guess you can too."

Time is money, they say. But whose money?

### BREAK THE PAIN-SPASM CYCLE OF NEUROMUSCULAR DISORDERS

# NEOCYTEN<sup>®</sup>





fast-acting, well-tolerated, analgesic-antispasmodic that breaks the cycle of pain-spasm-pain associated with rheumatoid arthritis, bursitis, lowback pain, etc. Combines pain relief of potentiated salicylate with skeletal muscle relaxant action of physostigmine salicylate. Muscarinic effects prevented by homatropine methylbromide. Now...sodium free.

DOSAGE: 2 tablets q.i.d., preferably before meals and at bedtime.

The Central Pharmacal Company - Seymour, Indiana





Sturdy, large gauge permanent aspirating tip pierces toughest vial diaphragm, withdraws solution easily. This unique VIM design permits easy, complete withdrawal of even the most viscous solution — ends bending, breaking, dulling of hypodermic needles because only aspirating tip pierces vials' rubber seal — greatly increases needle life.



A quick twist locks injecting needle on aspirating tip. Either VIM Stainless or VIM Laminez needles may be used.



Gabriel Aspirating Syringe

Available through your surgical/hospital supply dealer or write:

MacGregor Instrument Co., Needham, Mass.

MEDICAL ECONOMICS - JUNE 1957 R9

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# Twin benefits in peptic ulcer therapy

# ELORINE CHIORI

(Tricyclamol Chloride, Lilly)

# reduces gastric secretion

# and gastro-intestinal motility

Because 'Elorine Chloride' is capable of reducing gastric secretion and decreasing the motility of the gastro-intestinal tract (except the esophagus), it is especially valuable in the management of peptic ulcer. Other indications for 'Elorine Chloride' are functional digestive disorders, acute pancreatitis, diverticulitis, pylorospasm, and excessive sweating.

### Effective in peptic ulcer therapy

In a comprehensive study of anticholinergic agents, Sun and Shav! investigated the effect of a single "optimal effective dose" (O.E.D.) on basal gastric secretion. Under study were twenty-two patients with chronic duodenal ulcers which were secreting acid gastric juice continuously. The patients also received isotonic sodium chloride solution to rule out psychogenic factors. All drugs were administered intraduodenally. Results showed that 'Elorine Sulfate'\* produced a "pronounced and significant" decrease in mean gastric volume, free and total acid, and pepsin output.

# Longer suppression of gastric acidity

Duration of suppression of acidity was measured in sixteen patients. 'Elorine Sulfate' reduced gastric acidity to ph 4.5 or higher in all sixteen patients. This reduction was maintained from 30 to more than 270 minutes. In nine of the sixteen patients it lasted longer than three hours. The O.E.D. for 'Elorine Sulfate' varied from 150 to 500 mg.; this emphasizes the need for individual dosing.

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Pulvule 8 mg. ' Pulvule

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<sup>\*</sup>The 'Elorine Sulfate' (Tricyclamol Sulfate, Lilly) used in this study is therapeutically identical with 'Elorine Chloride' now available.

### Decreases basal secretion in emotional stress

In another phase of their investigation, Sun and Shay studied the effect of 'Elorine Sulfate' on gastric secretion stimulated by emotional stress.

One hour's basal secretion was collected. A disturbing thirty-minute interview based on a previously determined conflict was then conducted by a psychiatrist. Control basal secretion and secretion after emotional stress and after emotional stress plus 'Elorine Sulfate' intraduodenally were plotted.

In the stress situation without 'Elorine Sulfate,' an initial depression of gastric secretion was followed by a 700 percent increase in mean basal secretion during the third and fourth peak hours. The administration of 'Elorine Sulfate,' on the other hand, inhibited gastric secretion throughout the four-hour period fol-

### Dosage must be tailored to the patient

lowing the interview.

An effective dosage for the inhibition of gastric secretion varies greatly from one patient to the next. Thus, it cannot be administered according to body weight or in any recommended uniform dose. Dosage should be tailored to the patient's tolerance.

In peptic ulcer, the average adult dose ranges from 100 to 250 mg. three or four times daily.

'Elorine Chloride' is available in pulvules of 50 and 100 mg. at pharmacies everywhere.

### Achieving added sedative effect

For anticholinergic action plus a quieting effect, prescribe 'Co-Elorine' (Tricyclamol Chloride and Amobarbital, Lilly).

Pulvules **'Co-Elorine' 25** contain 25 mg. 'Elorine Chloride' and 8 mg. 'Amytal' (Amobarbital, Lilly).

Pulvules 'Co-Elorine' 100 contain 100 mg. 'Elorine Chloride' and 16 mg. 'Amytal.'

l. Sun. D. C. H., and Shay, H.: A.M.A. Arch. Int. Med., 97:442, 1956.

dentical Gilly ELI LILLY AND COMPANY - INDIANAPOLIS 6, INDIANA, U.S.A.

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it is good reason to specify

# CALCINATAL

which gives your patient phosphorus-free calcium, organic iron, balanced high level vitamin and minerals and aluminum hydroxide gel to bind a portion of dietary phosphorus.

It's trite to say "our tablets are small and easy to swallow" so write to us for samples in order that you may judge for yourself.

IN BOTTLES OF 120 TABLETS

## **NION CORPORATION**

LOS ANGELES 38 . CALIFORNIA

PROVED ...

in millions of doses in millions of patients

# Pentids

Squibb 200,000 Unit Buffered Penicillin G Potassium Tablets



New!

# PENTIDS for SYRUP

When prepared with 35 cc. of water, it provides 60 cc. of orangeflavored syrup supplying 200,000 units of potassium penicillin G per 5 cc. teaspoonful. 12-dose bottles. Effectiveness and safety confirmed by five years' experience in millions of patients

Convenient t.i.d. dosage—may be given without regard to meals

Economical for the patient far less costly than newer penicillin salts

Bottles of 12 and 100 tablets

**SQUIBB** 



Squibb Quality-the Priceless Ingredient

PENTIDS'S IS A RQUISS TRADEMARK



Antiprurient, soothing, and healing—
contains vitamins A, D, E, and d-Panthenol,
in a cosmetically pleasing water-soluble
base which fastidious patients will enjoy
using. Hoffmann-La Roche Inc., Nutley, N. J.

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uncomfortable as can be, but he simply has to be at work

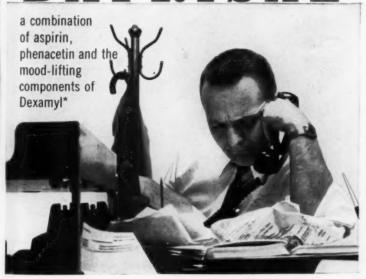
You see lots of patients with moderately severe pain or acute discomfort who insist on keeping up and about. Perhaps a painful, but not incapacitating, upper respiratory disorder. Or arthritis. Rheumatism. Lacerations. Bursitis. Possibly "shingles."

What to prescribe? Aspirin? APC? No. The patient needs more. Codeine? No. This patient's pain doesn't warrant a narcotic. Then what's the answer? 'Daprisal': the analgesic which

not only relieves pain but also lifts the patient's mood, helps him "feel better."

With 'Daprisal' you treat the whole patient, not just his pain.

# DAPRISAL



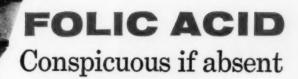
Smith, Kline & French Laboratories, Philadelphia \*T.M. Reg. U.S. Pat. Off.

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An important member missing. Just like a diet without adequate amounts of FOLIC ACID.

FOLIC ACID is similar to other members of the vitamin B complex in that it is vitally concerned in the formation of protein required by all body cells. Although many foods contain it some do not provide it in adequate amounts.

When prescribing for a vitamin deficiency consider the need for FOLIC ACID. Most leading pharmaceutical firms offer FOLIC ACID in suitable, convenient forms.

American Cyanamid Company, Fine Chemicals Division, 30 Rockefeller Plaza, New York 20, New York



MEDICAL ECONOMICS · JUNE 1957



# A doctor really on the move

appreciates the performance, the handling ease of his new Bausch & Lomb medical set. And its luxury look-and-feel adds more than a touch of esthetic pleasure. Ask your surgical supply dealer to show it to you.



Brilliant, shadow-free illumination, superlative optics, light weight aluminum heads, choice of battery handle sizes, sleek styrene pocket case.

98 MEDICAL ECONOMICS - JUNE 1957

Monodral and Meba trademark Functional and Organic Control

of

Gastro-Intestinal Irritability and Tension

# MONODRAL® with MEBARAL®

Potent

TABLETS

ANTISECRETORY - ANTICHOLINERGIC - SEDATIVE

Each tablet contains:

Monodral bromide 5 mg. Mebaral 32 mg.

Dependable control of hyperacidity and hypermotility. Spasmolysis. Prompt and prolonged pain relief. Tranquillity without drowsiness.

Peptic ulcer, 1 or 2 tablets three or four times daily. Other gastro-intestinal disorders, 1 tablet three or four times daily.

Bottles of 100 tablets.

Monadral (brand of penthienate) and Mebaral (brand of mephobarbital), trademarks reg. U.S. Pat. Off. Protective Coating with

# Creamalin

FAST ACTING REACTIVE GEL

# For best results in PEPTIC ULCER

rescribe Monodrai - Mobarai \* table in conjunction with Creamali

> Protective coating and mild astringent effect of CREAMALIN promote healing of peptic ulær.

> > CREA MALIN

Inhibition of vagus nerve by MONODRAL with MEBARAL results in reduction of acidity and hypermotility

DOSE

from 2 to 4 leaspoontuls Creamalin liquid or from 2 to 4 Creamalin tablets (well chewed) every two to four hours, with a small amount of water Creamatin liquid — 8 and 16 ft. oz. Creamatin tablets — bottles of 50 and

Winthrop

amolia (brand of aluminum hydraulde gel), Monadral (brand of penthianate)

dual action . . .

relieves tension-mental and muscular

# notably safe

Hijeth

ild MALIN c ulcer.

MALIN



enter antibiotic absorption

earlier therapeutic blood levels • faster brouposphat

spectrum action. Achievem V Capsulos are the new I

acting, oral form of Ackromycin- Tetracycline — offering

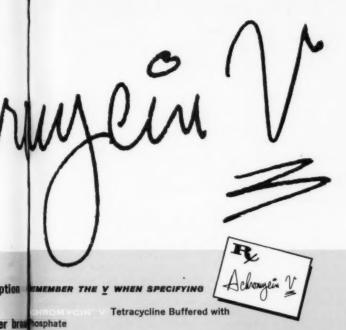
patients, on the average, twice the antibiotic absorption in

the time required by older preparations

100 MEDICAL ECONOMICS · JUNE 1957

25 mg. c and 16

or childre



APSULES—Each capsule (pink) contains tetracycline equivalent to 50 mg. of tetracycline HCl, phosphate-buffered. Bottles of 16 and 00 capsules.

VRUP—Each teaspoonful (5 cc.) of orange-flavored syrup contains 25 mg. of tetracycline HCl activity, phosphate-buffered. Bottles of and 16 fl. oz.

dosage: 6-7 mg. per lb. of body weight per day or children and adults.

DERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N.Y.



# see how Fostex helps in treatment of acne



TREATS THEIR ACNE WHILE THEY WASH

IN ACNE, Fostex Cream and Cake degrease and degerm the skin...unblock pores...remove blackheads and help prevent pustule formation. Both the Cream and Cake are well tolerated. And...Fostex is easy to use...assures patient acceptance and cooperation. The patient stops using soap on the affected areas and starts washing with Fostex.

Fostex effectiveness is provided by Sebulytic® (sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate, sodium dioctyl sulfosuccinate), a new combination of surface active cleansing and wetting agents with remarkable antiseborrheic, keratolytic and antibacterial action, enhanced by sulfur 2%, salicylic acid 2% and hexachlorophene 1%.



Fostex Cream for therapeutic washing of skin in severe, oily acne. Also as a therapeutic shampoo in dandruff and oily scalp.



Fostex Cake for therapeutic washing of skin after acute phase of acne is controlled. Maintains skin dry and comedone free.

WESTWOOD PHARMACEUTICALS Division of Foster-Milburn Co.

466 Dewitt Street, Buffalo 13, New York

ORTHO'S

MOST SPERMICIDAL CONTRACEPTIVE



used with a measured-dose applicator for simplicity, esthetic appeal and wider patient acceptance.



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# chances are 3 to 1 it'll be a Chest Film\*...

You might suppose a good chest film would be easy to take. Yet this "simple" examination is often very troublesome. The trick is to get consistent uniformity so films of a given patient taken at long intervals will always be dependably comparable in density and contrast. If you're an expert technician, you juggle kilovoltage, time, milliamperage and focal spot to suit each patient. If you're not, you guess...wrong, too often.

There's no guessing, though, when you work with a Picker "Anatomatic" x-ray control. It automatically integrates and sets up the whole complex of correct exposure factors for individual parts of individual patients. You need no charts, make no calculations.



\*National hospital surveys indicate that 33% of all roentgen examinations are chest films. Next in number are all extremities, averaging 10%.

#### here's all you do...

CHEST

72"

PA/Obl

- 0

dial the bodypart this chest station is one of 22 bodypart stations



2 set its thickness to the measured thickness of the part



3 take it

Companion to the Picker Anatomatic control is this efficient "Century" x-ray table ... a table with the rich look you'd expect to find only in upper-bracket x-ray equipment. The single tube converts from fluoroscopy to radiography and vice versa in a jiffy. 100 ma and 200 ma models.

Let your local Picker man tell you more about this remarkable x-ray machine .. or write Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.



now way in x-ray PICKER "ANATOMATIC"

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# the problem of the "vegetable" patient

The symptoms are all too familiar: apathy, paucity of ideas, repetition of vague complaints, sloppy appearance.

Very often, as an adjunct to specific therapy directed at the primary complaint, Dexedrine's gentle stimulation will provide this patient with a new cheerfulness, optimism and feeling of well-being that may again make her life seem worth living. Dexedrine\* (dextro-amphetamine sulfate, S.K.F.) is available as tablets, elixir and Spansule\* sustained release capsules. Made only by Smith, Kline & French Laboratories, Philadelphia.

\*T.M. Reg. U.S. Pat. Off.

10%.



When ardent persuasion is not enough ...



to maintain patients on a prescribed diet until conditioned to lower food intake, assign REVICAPS to police their appetite.

REVICAPS encourage dietary discipline by safely curbing appetite as well as hunger contractions during the initial difficult period of weight reduction.

REVICAPS combine all three accepted adjuncts to reducing diets: d-amphetamine, methylcellulose, vitamins and minerals.

Include REVICAPS in the reducing regimen you prescribe.

Available on Prescription Only

d - Amphetamine - Methylcellulose - Vitamins and Minerals Dosage: 1 or 2 capsules 1/2 to 1 hour before meals.



LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK #REG. U. S. PAT. OFF.

106 MEDICAL ECONOMICS - JUNE 1957

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accepted reducing medication



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W YORK

Desiccate those unsightly, possibly dangerous skin growths with the ever-ready, quick and simple to use Hyfrecator.

More than 100,000 instruments in daily use.

# THE BIRTCHER CORPORATION

Department ME-657
4371 Valley Blvd.
Los Angeles 32, California



Please send me your new full-color brochers showing step-by-step technics for removal of superficial skin growths.

Doctor

Address

City\_\_\_\_Zone\_State\_\_\_\_

MEDICAL ECONOMICS - JUNE 1957 107



# The gentlest doctors in town

use

# Nupercainal

soothing topical anesthetic

OINTMENT, 1%, in 1-ounce tubes with "peel-off" labels and rectal applicator; 1-pound jars for office use.

CREAM, 0.5%, in 14-ounce tubes.

OPHTHALMIC OINTMENT, 0.5%, in ophthalmic-tip tubes of 4.0 Gm. each.

2/201AM

108 MEDICAL ECONOMICS · JUNE 1957

- to control topical pain in minor office procedures and in the removal of surgical dressings.
- to control pain and itching in dermatitis, anorectal disorders, mucocutaneous lesions, chronic ulcers, abrasions, sunburn and other minor burns.

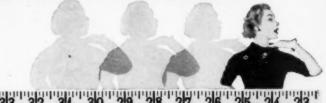
Nupercainal® Ointment (dibucaine ointment CIBA)

Nupercainal® Cream (dibucaine cream CIBA)
Nupercainal® Ophthalmic Ointment (dibucaine
ophthalmic ointment CIBA)

CIBA

SUMMIT, N. J.

specifically for reduction of overweight



26 25 24 3|3 3|2 3|1 3|0 2|9 2|8 2|7



"...a highly effective and safe appetite suppressant..."

Based on clinical reports, PRELUDIN produces more than twice the weight loss achieved by patients receiving a placebo.2 It is singularly free of tendency to produce serious side actions, as well as stimulation.1-3 PRELUDIN imparts a feeling of well-being that encourages the patient to cooperate willingly in treatment, 1-3

The reduced incidence of side actions with PRELUDIN makes losing weight more comfortable for the average patient, facilitates treatment of the complicated case and frequently permits its use where other anorexiants are not tolerated.3

Recommended Dosage: One tablet two to three times daily one hour before meals. Occasionally smaller dosage suffices. On theoretical grounds, PRELUDIN should not be given to patients with severe hypertension, thyrotoxicosis or acute coronary disease.

(1) Halt, J. O. S., Jr.: Dallas Med. J. 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.s Am. J. Digest. Dis. 1:155, 1956. (3) Natenshon, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956.

PRELIEIN® (brand of phenmetrazine hydrochloride). Scored, square, pink tablets of 25 mg. Under license from C. H. Boehringer Sohn, Ingelheim.

GEIGY Ardsley, New York



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3 A N. J.



# Antivert stops vertigo

(AND A GLANCE AT THE FORMULA SHOWS 2 REASONS WHY)

each tablet contains:

**MECLIZINE** (12.5 mg.) – specifically suppresses labyrinthine irritation<sup>1</sup>

NICOTINIC ACID (50 mg.)—for prompt increase of cerebral blood flow<sup>2</sup>

Proof? Try antivert on your next vertiginous patient. One tablet t.i.d. before meals. In bottles of 100 blue-and-white scored tablets. Rx only.



CHICAGO 11, ILLINOIS

VERTIGO IN GERIATRICS
ANTIVERT is particularly useful for the
relief of vertigo in the aging.

1. Weil, L. L.: J. Florida Acad. Gen. Pract. 4:9 (July) 1954. 2. Williams, Henry L.: J. Michigan State Med. Society 51:572-576 (May) 1952. N INDEP

# **Medical Economics**

NINDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JUNE, 1957 . VOL. 34, NO. 6



# Is Your Hospital Up to Par?

How many physicians does it take to make a hospital staff? How big an active staff and how big a courtesy staff do hospitals of various sizes need? Are surgical restrictions on the staff the rule or the exception in the typical hospital?

Some new answers to these old questions appear on the following pages. They're derived from a "prototype study" of nonprofit general hospitals in several size categories. The study was conducted by Louis Block, Dr. P.H., of the Public Health Service and reported in six recent issues of The Modern Hospital. It analyzes hospital operations in greater detail than has ever

S WHY)

#### IS YOUR HOSPITAL UP TO PAR?

been done in this country before.

How was the prototype study done? "National data were used whenever available," says Dr. Block. Where national data didn't exist, "regional, state, or special group information was adjusted to the national basis."

The comp statis sarily

# Make-Up of the Med

## Numbers of Staff Appointments in Hospitals of Various Sizes

- Active Staff
- Associate Staff
- Courtesy Staff
- Consultant Staff
- Other Staff

25-Bed Hospital



18 staff physicians

50-Bed Hospital



33 staff physicians

100-Bed Hospital



65 staff physicians

200-Bed Hospital



145 staff physicians

400-Bed Hospital



278 staff physicians

data e, or was The final result represents "the composite or average of existing statistical data . . . [not necessarily] the ideal institution."

Ideal or not, the figures that follow are definitely useful as norms. See how your own hospital stacks up against them.

# the Medical Staff

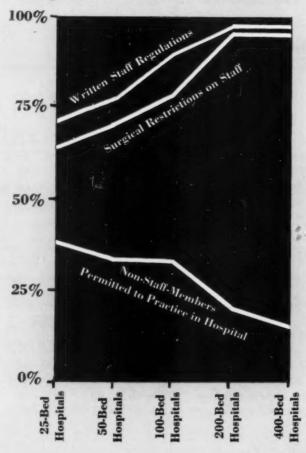
# Percentages of U. S. Hospitals That Have Various Types of Staff Committees

	25-Bed Iospitals	50-Bed Hospitals	100-Bed Hospitals	200-Bed Hospitals	400-Bed Hospitals
Executive committee	35%	70%	80%	90%	95%
Medical record committe	ee 32	50	80	90	95
Credentials committee	32	50	70	80	90
Tissue committee	12	35	60	75	80

# Percentages of U. S. Hospitals That Have Various Types of Staff Members

	25-Bed Hospitals	50-Bed Hospitals	100-Bed Hospitals	200-Bed Hospitals	
Chief of staff	87%	88%	95%	98%	98%
Chiefs of services	33	48	70	95	98
Specialists in radiology	33	60	90	95	98
Specialists in pathology	25	48	75	98	98

# Regulations of the Medical Staff



# **Facilities for the Medical Staff**

## Of all the hospitals studied . . .

From 85 to 99 per cent make laboratory facilities available to the staff's private ambulatory patients.

From 85 to 99 per cent make X-ray facilities available to the staff's private ambulatory patients.

From 30 to 45 per cent make examining rooms available to the staff's private ambulatory patients.

From 15 to 25 per cent make private offices in the hospital (or on hospital grounds) available to the staff.

## In all sizes of hospitals studied . . .

From 15 to 30 per cent of all beds are specifically set aside for obstetrical cases.

# In the larger hospitals studied (100, 200, and 400 beds) . . .

From 12 to 14 per cent of all beds are specifically set aside for pediatric cases.

# Other Hospital Facilities

## Percentages of U. S. Hospitals That Provide the Services Shown

	25-Bed Hospitals	50-Bed Hospitals	100-Bed Hospitals	200-Bed Hospitals	400-Bed Hospitals
Ambulance service	78%	80%	80%	80%	92%
Hospital blood bank	35	50	66	80	90
Hospital pharmacy	25	40	66	90	100
Infant incubators	20	80	90	93	95
Post-op. recovery rooms		12	25	40	66

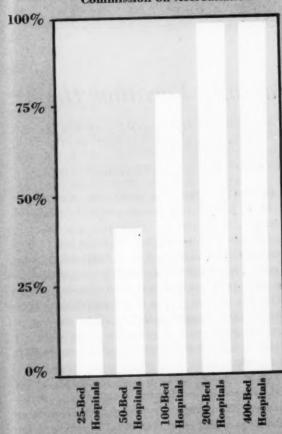
<sup>\*</sup>Insufficient data for an accurate percentage

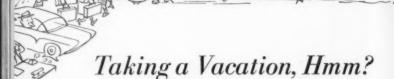
# **Administrators and Accreditation**

# Percentages of U. S. Hospitals That Have Various Types of Administrators

	Hospitals 23-Bed		100-Bed Hospitals	200-Bed Hospitals	400-Bed Hospitals
Physician-administrato	r 20%	10%	10%	12%	15%
Nurse-administrator	45	45	42	38	30
Lay administrator	35	45	48	50	55

# Hospitals Accredited by the Joint Commission on Accreditation





Any doctor can PLAN, says this confirmed optimist.

On the other hand, if you really want to GO . . .

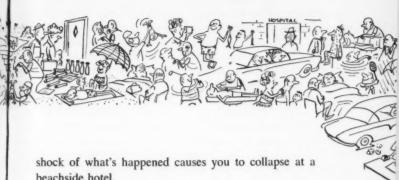
By Theodore Kamholtz, M.D.

A vacation is something a doctor plans nine months ahead and postpones nine minutes before he's supposed to leave.

Legal advice to the contrary, the surest way to get a vacation is to fall suddenly ill in La Jolla while hurrying to make a house call in Hoboken. This accidental situation develops from a strange series of coincidences:

One day you just happen to put your hibiscus sport shirt, yachting cap, and open-toed sandals in a valise. Your wife wants you to drive her downtown on the way to your first house call. And the kids ask to go along for the ride.

You head for the center of town when—wham! The road switches on you and you are pointed southwest. Somehow, this circumstance doesn't come to your attention until 3,000 miles later, when the children suddenly remark that Hoboken was never like this. The



beachside hotel.

All vacations other than this surefire one have a time of conception, a period of gestation, a moment of parturition-and a high percentage of stillbirths. Titillating yourself with talk about getting away from it all gets you nowhere if hospital appointments do not permit.

As it works out, during even months you're on call at Hospital A, during odd months at Hospital B. Hospital B is smaller than Hospital A, but Hospital B is the more important to you. On the other hand, Doctor D can cover for you at Hospital B if that doesn't conflict with his own time at Hospital C. You must also consider your halfdozen expectant mothers, for whom your vacation is only D day plus or minus 7.

In the long run, you settle on a time that's poor for you, your wife, and your children, but reasonably convenient for the rest of the world. Yet this needn't discourage you; for whenever you go, you'll find it's the rainy season, or the beaches are snowbound, or the pools are dry.

The next problem is where to go. Actually, this is not your problem at all; because no matter what place you name, your family will think up twenty good reasons for panning it. Either they've been there before and are

sick of it, or they've never been there but they've heard that it's simply awful.

Anyway, the wrong people go there. Or there aren't enough of the right sex. The crowd is too young or too old. They do or they don't dress for dinner.

Since you were allowed the privilege of setting the *time*, the family demands the prerogative of setting the *place*. All this leaves you is the dubious pleasure of a smug smile when the complaints start rolling in midway through the vacation.

If—as is most unlikely—you

should be stuck about where to go, the travel agencies are more than pleased to help you out. They shower you with seductive folders and will plan complete vacations "at ridiculously low prices that you would never have dreamed possible."

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Of course, if you want a room with a window, there's an additional charge of twenty bucks a day. And if you'd care to make any of those interesting side trips to the interior of, to the top of, or through something, you merely double the daily room rate.



"Dr. Arthur? Could you phone a prescription for that mycin stuff to Bailey's Drug Store?"



"What's the matter with you?"

Clothing is no problem for the doctor either. But it holds the feminine contingent of the family enthralled. One school of thought suggests that the women buy their vacation clothes at regular intervals over the entire vacation-planning period, thus spreading joy to the chronological maximum.

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The big hitch is that any garment bought more than a week before leaving is *old*; and for a vacation one must have something *new*.

The other school encourages the little ladies to buy all their

comes before the happy anesthesia has worn off.

Regardless of which school the girls belong to, it's safe to say that whatever clothes they buy will be wrong and too few. So the minute they arrive, the shopping spree begins all over again. This despite the baffling fact that of the ten assorted

clothes in a last-minute orgy.

Then if vacation plans must un-

expectedly be canceled, the pain

pieces of luggage that accompany your family, you have unrestricted use of only one-half of the smallest piece and must tote your razor and toothbrush in your pocket.

Now consider who'll cover your practice for you while you're away: Of the physicians who might do so, Doctor A hasn't got privileges in your hospital, you don't like Doctor B, you can't trust Doctor C, and Doctor D is already covering for Doctor F.

Doctor F could make your house calls except that he's 75 and doesn't like to make house calls any more. Doctor G wouldn't think of covering your practice, since he was mortally offended when you let Doctor H cover it two years ago. [MORE ]



"Nothing. It's for my parrot. He's got diarrhea."

Doctor I won't walk on the same side of the street with you because a patient of yours married his nurse when he covered for you last. Doctor J is leaving for National Guard duty midway during your vacation. And you can't ask Doctor K because he's your chief.

The solution? you call Doctor L in a near-by state. He's glad to cover for you, even though he lives sixty-three miles away, because you promise to cover for him in turn.

#### 'I Need a Rest'

Gradually, in advance of your leaving, you have time to prepare your patients for the fact that you'll be away. You begin by talking vaguely about needing a rest. You underline it dramatically by holding several office hours unshaven. Pretty soon you narrow it down: "I need a rest beginning a week from Thursday at 2:30 in the afternoon."

When your women patients object and weep because they cannot think of exposing their dietary indiscretions to a stranger, it's time to glance down shyly and say you're going to celebrate your twenty-fifth anniversary. In the women's league,

this sentimental gambit never fails. After all, their own husbands never remember how many years they've been married.

As the hysteria of your imminent departure increases, you can even let fall the suggestion that it's really your wife who needs the rest. That does it!

#### **Legal Details**

The next items in planning your vacation are purely technical: You visit your lawyer, sign a new will, have him get your estate in order, and pay him a nice fat fee.

You then call the plumber, carpenter, and electrician and have both home and office put in moth balls. Despite all these precautions, you can be sure that your sterilizer will be burned out before you return and that you will need a new refrigerator.

The last step is to borrow money on your life insurance, take out a second mortgage on your house, and wipe out your savings account. Now you're ready to go—or almost ready.

The time is 2:30 minus nine minutes—an interval just long enough for all hell to break loose. The calamity that threatens you

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122 MEDICAL ECONOMICS · JUNE 1957

may be anything from double pneumonia in your youngster to having your rich uncle drop in from Alaska. It's during this critical period that preparedness is the watchword.

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Luckily, you're not defenseless. Here are several things you can do to avoid an untimely interruption:

First and foremost, rip out the telephone nine minutes before you leave. This spares you emergency hemorrhoidectomies, appeals from relatives for money to save the family factory, and warnings from radio-listening neighbors that the area you're heading into is one of epidemic pediculosis.

Don't answer doorbells. You then won't receive the telegram recalling you to active duty. You won't have to suture the lacerated scalp of the boy next door. Nor will you be forced to make your exit while diagnosing a hepatoma.

Don't take in the morning mail. You then won't learn that you've been appointed this month's chairman of the Bubonic Plague Subcommittee of the State Hygiene Association. Nor will you see the raft of new bills that would make the whole vacation impossible.

Don't pick up the newspaper. You may read what happened to the stock market. Or you may spot headlines about a new world crisis that's guaranteed to make you feel like Nero fiddling while Rome burns.

In short, close the door. Lock it from the outside. Be deaf and blind even when a car and a truck crash headlong on your corner.

You're off!

END

## **Cold Common Sense**

What makes the common cold so common

Is all the kissin' kin

Whose cocktail party credo is

No germ can live through gin.

-COLBY CLEVELAND



# How Do Good Do

#### 2. The Influence of Your Medical Education

EDITOR'S NOTE: Apparently most of us have been cherishing some false notions as to the type of training, experience, and practice methods that help to make a doctor good. This conclusion emerges from a pioneering study sponsored recently by the Rockefeller Foundation. Though the study was intended solely as an appraisal of general practice—and of the type of training most likely to turn out competent G.P.s.—it's of interest to every doctor, no matter what his field. This article is the second of several summing up the study group's revelations.

In asking its alumni for contributions, your alma mater probably plays variations on the old theme song, "We Made You What You Are Today." But does your medical school really deserve credit for the level of practice you maintain? The answer seems to be an almost unqualified "No."

That conclusion emerges from a study of eighty-eight G.P.s made recently by researchers from the University of North Carolina. Purpose of the study: to find out what it takes to make a really competent doctor. Study method: a comparison of the doctor's clinical skill (as rated by the researchers) with his education, medical society and hos-

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# ood Doctors Get That Way?

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pital affiliations, practice methods, study habits, and so on.

Last month I described how the researchers went about rating doctors' clinical skill. Here's a brief recap of what they did:

One researcher (and sometimes two) followed each G.P. through three or four days of office, house, and hospital calls. The G.P. was graded on six activities: history taking; physical examination; use of laboratory aids in diagnosis; therapy; preventive medicine; and keeping of clinical records.

Then the researcher summed up his observations by assigning the doctor to one of five ranks designated by Roman numerals. Numeral V stood for an excellent clinical performance, I for a very poor one, with III "average" or fair. Ranks II and IV represented intermediate grades. The number of G.P.s finally assigned to each rank was as follows:

#### V..7 IV..15 III..27 II..23 I..16

At this point the researchers turned their attention to the educational backgrounds of the men in the various ranks. They wanted to find out whether the training received by the above-average doctors differed from that received by those rated as average or below-average—and, if so, in what way it differed.

What they found surprised them—and it will probably surprise you, too. It may also help you do a better job of planning your own future refresher training.

The study team went all the way back to medical school admissions records. Medical College Aptitude Test scores for thirty of the men (and medical school grades for all of them) were obtained from their medical school deans. A comparison of these figures with the doctors'

# G.P.s' Medical School Standing Compared with Later Clinical Performance, by Age Groups

Researchers studied the clinical performance of eighty-eight G.P.s and then assigned each man to one of five numerical ranks. The middle rank is 3.0; a higher figure represents an above-average performance; anything below 3.0, a relatively mediocre one. The table shows that G.P.s who had been outstanding medical students were also outstanding clinicians up to age 35—but not beyond. The figures in parentheses show the percentages of the North Carolina men who'd been in the top, middle, and bottom third of their medical school class.

	How Doctors	Ranked Later	as Clinicians
How Doctors Ranked As Medical Students	Average At Age 28-35	Average At Age 36-43	Average At Age 46-65
Top third of class (21%)	4.2	3.0	2.8
Middle third of class (48%	) 3.3	2.5	2.0
Bottom third of class (31%	) 1.5	3.7	2.3

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A man's score on the Medical College Aptitude Test doesn't indicate how good a medical student-or doctor-he's likely to be. So if admissions committees rely too heavily on such scores, they may not always choose the most promising students.

Admissions committees are popularly supposed to be partial to doctors' sons. So the study team next had a look at the G.P.s' family backgrounds. Their fathers had been professional men, business executives, teachers, ministers, accountants, merchants and small entrepreneurs, farmers, skilled and unskilled workmen. Finding:

#### Like Father, Like Son?

Doctors' sons aren't any more likely to become good doctors than anyone else. The only group that ranked slightly better than average in the North Carolina study were the sons of executives. The sons of merchants and small entrepreneurs ranked slightly below average. Conclusion: "The father's occupation is of little importance" in the making of a good general practitioner.

How important was the choice of medical school? Thirty-two different medical schools were attended by the North Carolina men. Did it make any difference that some schools graduated an unusually high percentage of teachers and researchers, while other schools put more emphasis on practical medicine? Did the twenty privately supported schools turn out better qualified G.P.s than the twelve state universities? The study group's finding:

#### 'Schools Are All Good'

The type of medical school a doctor attended seems to have no bearing on his clinical performance-at least as far as general practice is concerned.\* This may be because "present-day medical schools in this country are all very good and [offer] almost identical curricula," the study team adds.

Presumably, then, a man who got high grades at one medical school might have done just as well anywhere else. But do those

e"In the case of some schools, a large percentage of graduates remain in medical education or enter specialist practice," says the study report, published in December, 1956, by the Association of American Medical Colleges. "It is possible that general practitioners graduating from such schools are not representative of their schools' graduates."

#### HOW DO GOOD DOCTORS GET THAT WAY?

high grades indicate he's likely to be a good doctor? Finding:

The best medical school students tend to become slightly better than average doctors. Among the North Carolina G.P.s who'd been in the top third of their class, 44 per cent were rated in the two top ranks (Ranks V and IV) as clinicians. Only 20 per cent of the "middle third" men and 23 per cent of the "bottom third" men were rated that high.

But the average rank of all the "top third" men was only a trifle higher than that of the other two groups. "The difference is not striking," say the researchers, "and the range of performance, even among the top group of students, was wide."

In other words, good grades don't guarantee a good doctor any more than they do a good lawyer, a good general, or a good playwright.

# How Medical Education and Training Relate to Clinical Skill

The North Carolina study shows that a G.P. is likely to be an above-average doctor if he had:

- High medical-school grades (and is under 36)
- More than three months' hospital training in medicine

The study shows no significant relation between clinical skill and:

- 1. Score on Medical College Aptitude Test
- 2. Father's occupation
- 3. Type of medical school attended
- 4. Quality of hospital training
- Length of hospital training in surgery, pediatrics, or obstetrics and gynecology

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This may mean that medical schools emphasize some subjects that don't help their graduates in daily practice. It may also mean that many good students gradually relax their standards after leaving school.

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The latter point seems to be borne out by the researchers' next finding:

#### Young Men Excel

Up to the age of 35 or so, men who did well as medical students do an outstanding clinical job. After that, they let their standards slip somewhat, judging from the table on page 128. At the same time, some of the poorer students acquire skills they weren't taught in college. But after reaching 45, most doctors -whether they were good or poor students-seem to be less careful about keeping their clinical standards high.

#### Residency Evaluated

What about the effect of hospital training? The North Carolina men had had anywhere from sixty months of hospital training to none at all. After matching these figures against the doctors' dinical rankings, the researchers concluded:

The length of time spent in interneships and residencies has little relation to clinical performance. True, the five North Carolina doctors with more than thirty months of hospital training all ranked average or better. And three-fourths of the men who'd had no interneship at all were ranked at the bottom as clinicians. But between these two extremes, the researchers couldn't find any link between length of training and clinical skill.

#### Average Training Time

In fact, the "average" clinicians had almost twice as much hospital training as the top-rated clinicians in Rank V. The average length of hospital training, in months, for each of the five ranks was as follows:

If the length of hospital training isn't very significant, what about its quality? If a man spent all his training time in a teaching hospital, is he likely to be a better doctor than the next man? Finding:

There's no clear relation between quality of hospital training and clinical [MORE ON 278]



# Should You Te

EDITOR'S NOTE: For centuries, doctors have tortured themselves with the question: "Should patients be told the truth about serious illness?" Now, a book due for publication this month reports a panel discussion of the issue by five men, all of New York: Dr. Claude E. Forkner, Professor of Clinical Medicine at Cornell University Medical College, chairman; Dr. Carl Binger, Consultant in Psychiatry, Massachusetts General Hospital; Dr. Arthur M. Sutherland, Assistant Professor of Clinical Medicine, Cornell University Medical College; the Rev. Theodore C. Speers, pastor of the Central Presbyterian Church; and George A. Brownell, partner in the law firm of Davis, Polk, Wardwell, Sunderland and Kiendl.

The book in question is Volume 6 of "Practitioners' Conferences Held at New York Hospital-Cornell Medical Center," published by Appleton-Century-Crofts, Inc. What follows here is a condensation of parts of it. to

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# ou Tell Patients the Truth?

Medical-lay symposium roughs out some guidelines for dealing with a question that has no pat answer

DR. BINGER: Our question is: "Should Patients Be Told the Truth About Serious Illness?" Those who uphold the negative would have to say "No, patients should be told lies about it." And that would be hard to defend.

I myself would have framed the question: "Should every patient be told the facts about his illness; or should the doctor use some discretion?"

The guiding principle should be, "Will what I tell him help him recover from the illness for which he has consulted me?" Here are a few cases in point:

A lady consulted me a few years ago, more as a friend than as a physician, because she had a wart on the shin of her right leg, which was quite apparent through her stocking. The lesion was obviously of no consequence; but in the process of examination, I noticed an inky black spot on the shin of the other leg. Without letting her know it, I paid more attention to the black spot than I did to the wart. I then sent her to a dermatologist, telling him that I thought she might have a melanosarcoma.

The dermatologist removed the wart, but he also exised a skin flap surrounding the pigmented area. The tissue

was sent to a pathologist who made a diagnosis of melanosarcoma.

I told the patient nothing except that she had a wart and that the other spot was unsightly and had better be removed. This was a woman of about 50 who had the same fear of cancer that many women her age have.

When I first examined her, I felt in both inguinal regions. There were obviously no enlarged nodes. Thereafter, for a month or so, I re-examined the inguinal nodes each week. But nothing ever came of it.

This happened ten years ago. The patient is alive and well. She does not know she had a serious lesion that might have resulted in her death had it been irritated.

It seems to me only the part of wisdom and decency not to say to such a patient, "Look here, this is pretty serious business. It could easily develop into cancer. You'd better have it attended to immediately."

Of course, we are occasionally put on the spot, as when a patient says, "I have come to you because I want to know the exact truth. Have I cancer or not?" In such a case we tell him the exact truth.

In my own field of psychiatry, I'm sometimes astounded by the direct questions I get from patients. Young people who are disturbed will suddenly say to you, "Doctor, do you think I'm a schizophrenic?" I see no excuse for answering the question with a direct "yes." Such information does not help the patient to manage his life.

### Fear of the Unknown

DR. FORKNER: Dr. Binger, do you feel that seriously ill patients are more afraid of the unknown than of the known? Suppose a patient with metastases to the bones is told he has "a little arthritis" or a patient with leukemia is told he has "anemia." Then suppose his condition gets progressively worse. What happens?

In my experience, such a patient will lapse into a state of great fear. The truth, even though devastating, seems less hard to take.

DR. BINGER: Some patients are more comfortable with relatively little knowledge. Some want to know everything. I would not say that one method is right for all.

DR. SUTHERLAND: "Should Patients Be Told the Truth

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About Serious Illness?" presumes a standard disease, a standard patient, and a standard physician—none of which exists. Therefore, a single, simple rule which will cover all instances does not exist either; and to seek such a rule is a waste of time.

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I do not know anyone well enough to predict with sureness his reaction to news of a serious illness. How he has reacted to stress in the past is no guide to how he will react now.

DR. FORKNER: When patients are told the truth, I find they develop a kind of protective mechanism. They become easier to handle. I don't really understand this.

# The Minister Speaks

REV. SPEERS: The other day I was called to the hospital to see a young doctor who'd been told he had leukemia. The first thing he did was introduce me to a young priest who had a serious malignancy.

Both these men knew what they were up against. But they exhibited such poise and courage as to give a lift to everyone who saw them.

Had we pussy-footed with these two men and told them a lot of cock-and-bull stories, it would have been unforgivable. People deserve a chance to show the stuff they have in them.

Dr. BINGER: In a fatal illness, it is often the decent and humane thing to face the facts with a patient. I have done so many times.

# Help Him to Live

But we are not talking here about fatal illness only. The question reads "serious illness." While this may cripple the patient and may interfere with his usual activity, it is our job to try to retain as much of his functioning as we can—not prepare him for death.

REV. SPEERS: It seems to me at this point that nothing is of more value to the patient than the complete trust he has in his physician. Anything that undermines that trust undermines the healing power of the physician. If the patient finds the doctor has not been giving him all the facts, his confidence will crumble and much of the doctor's usefulness to him will have ended.

Dr. SUTHERLAND: A patient's ability to absorb threatening information depends on the relationship between him and his doctor. Information is received very differently from a physician

who's warm, supportive, and kindly than from one who's cold, commercial, and experimental.

Cancer is not just a diagnosis; it's a sentence. What to tell a patient depends on the aim of the information. Are you trying to teach the patient to be an authority on his disease? Or are you trying to get his cooperation in treatment and to help him avoid anxiety?

DR. FORKNER: Mr. Brownell, we have left you out of the pre-

liminary discussion. Yet it is often important for business and legal reasons that a patient face the issue of a serious illness. If he doesn't, his affairs may be left in a terrible state. He may not have a will. He may not have done what he wants to do with his property. He may not have revised his estate to take fullest advantage of possible tax savings. And so forth.

There's also the matter of the doctor's legal responsibility if he



"602 wants service."

134 MEDICAL ECONOMICS - JUNE 1957

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knowingly tells the patient an untruth about his illness. Will you make a few comments, Mr. Brownell?

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# The Legal Angles

MR. BROWNELL: There is no general legal principle that lets a doctor tell a patient an untruth with impunity under all circumstances, no matter how high his motives. In fact, a doctor is just as liable for a negligent diagnosis as he is for negligent treatment.

True, some lawyers believe that doctors should have a qualified privilege in cases of serious illness. But I find nothing in the decided cases that establishes that principle.

There is, however, a very interesting article in 19 Tennessee Law Review 349, by Hubert Winston Smith, a professor of law, in which he advocates the creation of such a privilege to be available in cases where to tell the patient the truth would have the reasonable probability of resulting in his death or serious injury. Professor Smith's article cites the only case I have seen in print:

There was a Mrs. Brown who came to a doctor for examination. She had a lump in the breast and she told the doctor if she had a cancer she was going to commit suicide. She was obviously in a very nervous condition and was almost a psychiatric case.

The doctor examined her. While he found that she did in fact have a cancer, he told her she did not, but that she should nevertheless have an operation on the breast.

# **Malpractice Trap**

Radical surgery was performed. A couple of years later the woman found out the truth. She brought suit against the doctor for malpractice and also for inducing her to submit to an operation on the basis of a false statement.

Counsel for the doctor argued the existence of the qualified privilege I've spoken of because of the unusual circumstances of the case. He also argued that no damage had been proved and that if the operation had not taken place the lady probably would have died during the course of the two years. A verdict for the doctor was directed.

Now suppose a man comes to you and says, "I want an examination. I want to be told the truth," and you agree. Then suppose that after you examine him you decide his life will be a lot happier if you don't tell him the truth, so you withhold it. I think as a matter of law you are then open to serious criticism.

What about the other part of the lawyer's approach? It is often of the greatest importance that the individual know the facts so he can put his affairs in shape.

### **Economic Considerations**

He may have a business that should be wound up or sold if he is not going to be able to continue to run it. It may be one of those family businesses in which all the assets the man owns are invested and where there may not be enough ready cash in his estate to pay taxes unless it is sold. If the man dies without warning, it may be necessary to sell the business under pressure and under less advantageous circumstances than would have been possible during his lifetime.

It's perfectly obvious, too, that a man should know the facts in order to prepare or revise his will. It may make the difference between a life of reasonable comfort for his widow and children and one of just getting by. For example, wills written before the marital deduction was allowed in our Federal tax law now sometimes require payment of a large percentage of the estate in taxes that could be avoided if the wills were rewritten.

# **Tell His Lawyer**

If there is a family lawyer, I believe that, regardless of the question of privilege, you should talk the patient's situation over with him. Or you can talk to your own lawyer and, without mentioning names, find out what he thinks about the case.

DR. FORKNER: I had a patient who suspected she had carcinoma and had been worried and sleepless for several weeks. "Dr. Forkner," she said, "if I have cancer I'm going to jump out of this 14th floor window."

We did a biopsy and a few days later established that she did in fact have carcinoma. As I entered the room she asked point blank: "Do I have cancer?" and I said, "Yes, you do."

I then sat down and explained the situation to her in an hourlong talk. That night she slept peacefully for the first time in a long while. Not once again did she mention suicide.

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for thirty years with chronic myelogenous leukemia and finally died of the disease. In the meantime, while she knew the facts, she supported a family and gave every appearance of leading a happy life. Doctors do not know when patients are going to die, and to say that they do is to make a serious error.

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What About Suicide?

MR. BROWNELL: The case that interests me most is the one where you are reasonably certain that a man has a cancer and that his life is going to be limited. Can't you also be reasonably certain that if you tell him the truth it will have an adverse effect on him—for example, by making him try to commit suicide?

Dr. BINGER: I doubt whether anyone commits suicide simply because you tell him something. People commit suicide for different, inner reasons.

I also think the semantic implications of what you say to a patient are most important. The word arthritis, for example, may connote a wheel chair, losing one's job, being crippled. Another word may be much less frightening.

But I should like to return to

the original question, which I think is the important one: Shall we tell the patient all the facts or only some of the facts?

### Can Doctors Be Sure?

MR. BROWNELL: I do not think that is the problem. I repeat the earlier question, to which I have not yet had an answer: Are there cases when you doctors can assume with reasonable certainty that to tell the man the truth is going to have a serious effect on his physical condition?

DR. FORKNER: I have not myself encountered the fact of a patient being seriously damaged by telling him the truth.

DR. SUTHERLAND: I have. I have seen several cases in which serious depressions and psychoses with frank delusional states were precipitated by this sort of information which the patient was not able to handle.

# A Moral Question?

DR. BINGER: I'm not quite clear whether Dr. Forkner's stand is based on the moral precept that it is good to tell the truth, or on the pragmatic experience that this works best for the patient. If it is on the latter, I must ask him if he's ever tried

the control experiment. Has he ever tried not telling the patient the truth? And how does he know that one system works better than the other?

DR. FORKNER: It is not a moral question with me. It is a matter of being fair to the patient and of doing what I think is best for him. I find that if a patient doesn't get the facts from his physician, he may quite possibly get them from someone else. We have a patient in the hospital now who says she found out from the dietitian's chart that she has Hodgkins disease. Her doctor had not told her.

I feel that to take the patient into your confidence, treat him as if he were intelligent, and meet whatever situation arises tends to bring about the most satisfactory response.

# 'Let Him Air His Fears'

DR. SUTHERLAND: Allowing the patient to discuss his fears with you can be enormously helpful. In fact, the more you let him air his fears, the more you reassure him. When you do this, you are doing more than merely giving information. You are establishing a warm, supportive relationship.

# Patient Data Form Aids Collections

When a physician fails to get complete information about a new patient, his bills may later go to the wrong person. Even if they don't, his collections are likely to take extra time and trouble. What seems to be needed is a patient registration form that solves the problem.

One such form is shown here. It was devised by the Medical Bureau of Harrisburg, Pa., a medical-society-sponsored agency. At present the form is being used by some 150 Harrisburg doctors.

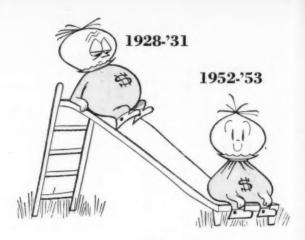
When the Medical Bureau first began distributing the forms, it explained the need for them with this example: "Doctors carry [many of] their accounts receivable records under the names of minor children, without reference to parents or guardians... What a time [the] bureau [then] has trying to prove liability where parents are divorced or separated!"

The bureau's form is meant to be filled in by patients themselves, and is complete in itself. It even asks for data on insurance coverage—which, the bureau comments, is "as important today as the name of the patient."

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w pato the don't, take DEAR PATIENT: To assist the doctor in keeping accurately your Personal Professional Record, please complete

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(FA)	(HUSBAN	HHOW LONG 10 MORTHS PHONE H SULT-8044
PREVIOUS ADDRESS 1106	1106 Pen avenue	HOW LONG 5 YRACS
PATIENT'S NAME Harriet	AGE 14	RELATIONSHIP TO HEAD OF FAMILY CAUGHTEC
EMPLOYMENT OF PATIENT SHUC	Student	
EMPLOYMENT OF HEAD OF FAMILY_	Secretary, Harrisburg	EMPLOYMENT OF HEAD OF FAMILY SECTETARY, HARTISDIARY COOL AND Oil Co., 430 1745 St.
IS PATIENT COVERED BY ANY FORM	A OF INSURANCE (MEDICAL, SURG	IS PATIENT COVERED BY ANY FORM OF INSURANCE (MEDICAL, SURGICAL, HOSPITALIZATION) YES (X) NO ( )
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ADDRESS OF RESPONSIBLE PERSON.	same as above	
	Mee IN H Williamson	



# The Real Cost Of OB Care Is Down

A comparative study indicates that while the quality of obstetrical care has been steadily rising for years, its relative cost has been just as steadily declining

"Contrary to the trends in most medical and hospital care and in living costs generally, the comparative costs of maternity services have decreased in the United States since 1928-31..."

That's the surprise finding of the Health Information Foundation, which recently compared the two most massive studies of medical costs done during the last quarter-century. The first study covered the years 1928-31. The second study covered 1952-53. Results of the H.I.F. comparison show that:

¶ Taking inflation into account, OB patients pay 18 per cent *less* for having a baby than they paid twenty-five years ago. They pay 27 per cent less for hospital and nursing services combined—mainly because their hospital stay has been cut on the average from twelve days to five.

¶ OB patients pay 9 per cent *more* to M.D.s—again comparing costs in comparable dollars. But they get better care for their money. Maternal deaths run less than 5 per 10,000 live births, or about one-tenth the maternal death rate of twenty-five years ago.

# What Price Maternity Services?

Type of Service	Ce	ual ost 3-31 <sup>1</sup>	1928-31 Cost Ex- pressed in 1952-53 Dollars <sup>2</sup>		etual Cost 52-53 <sup>3</sup>	% Dif- ference
Hospitalization	\$	63	\$102	\$	92	-10%
Special nursing service						
in hospital		15	24			-6
Physician's service		57	92	1	100	+ 9
Other services	_	25	40	_	21	-47
All maternity services	\$1	160	\$258	\$2	213	-18%

All figures shown are averages. <sup>1</sup>From a study by the Committee on the Costs of Medical Care. <sup>2</sup>Based on the Consumer Price Index. <sup>2</sup>From a study by the Health Information Foundation. <sup>4</sup>Figure too small to be included. <sup>5</sup>Percentage not calculable.

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# 6. THE CASE OF THE

By Xavier F. Warren

EDITOR'S NOTE: Here is the sixth in a series of true incidents selected from the confidential file of a malpractice insurance company's claims adjuster. Although names and identifying details have been changed, the stories accurately portray recent happenings.

One year we arranged group malpractice coverage for a medical society some 500 miles away from our home office. I was sent to the annual meeting of that society to complete the arrangements. While there I attended the society's banquet.

The toastmaster was wonderful. He was a Dr. Cyrus Fargo, one of the members. The officers had told me beforehand: "Cy Fargo should be on television. He's an absolute riot."

And they were right.

I was to know Cy Fargo well, in spite of the 500 miles between his office and mine. He got into malpractice trouble because of the very quality that made him such a good entertainer. He said something funny—but at the wrong time.

Dr. Fargo was an obstetrician. Patients said they felt

malpractice mishaps!

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# WELL-MEANT QUIP

better just listening to him. He was always so jolly, so reassuring.

He had a large but by no means wealthy practice. Many of his patients were Negro, many were white. It didn't matter to Cyrus Fargo. The Negro and white women sat in the same waiting room at the same time and waited their turn.

One day he delivered a Negro woman of her first-born. It was a stillbirth. Nobody's fault—just one of those things.

But in a subsequent malpractice claim, the patient, via her lawyer, listed five procedures of sound obstetrics which, she asserted, Dr. Fargo hadn't followed.

Our own obstetrical adviser reviewed the record and said that Dr. Fargo was in the clear except that he probably should have used a pelvimeter. To be sure, the woman probably looked as if she had a roomy enough pelvis; but . . . well . . . he really should have taken those measurements.

The plaintiff indicated she wouldn't settle for less than the \$5,000 she was suing for.

Her stated reason: "To teach white doctors to respect Negroes."

When this word was relayed to me, it mystified me

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completely. Dr. Fargo was obviously no bigot. He couldn't recall having said anything that might have put a chip on this woman's shoulder.

It wasn't until the plaintiff herself spoke up at the pre-trial examination that we found out what was at the root of the trouble:

PLAINTIFF: So they said my baby was dead.

ATTORNEY: And what did Dr. Fargo say or do then?
PLAINTIFF: He laughed and said, "Sorry, Nellie, but
I know you'll get pregnant again real soon. Think of all
the fun you'll have trying. And then we'll do better next
time. Besides, it's just too doggone hot to have babies
in July"...

As soon as we took a recess, I asked Dr. Fargo about this alleged conversation. He couldn't recall the exact words, but he admitted it was in character.

"Good Lord," he protested, "I was only trying to cheer the poor woman up. I didn't mean what she must have thought I meant—that Negroes have babies more casually, or don't feel their loss as sharply, or anything like that."

American juries, however, will not tolerate the idea of any doctor's adding fuel to smoldering racial fires. They will not tolerate the taking of births and deaths lightly. They will not tolerate second-grade medicine for people with second-grade incomes.

And any remark that can be interpreted as reflecting the wrong attitude on any of these counts is likely to destroy the doctor's defense.

Anticipating this, we decided to save court costs. We settled right then and there for \$5,000.

Nowadays Dr. Fargo is careful to keep his quips out of the delivery room.

# Can You Pass This Business Quiz?

Test yourself on these multiple-choice questions, then compare with the correct answers on page 148

By Thomas Owens

1. In a prospectus offering a new issue of stock there's a balance sheet showing the company's financial condition. The statement is labeled "pro forma." Does this mean...

(a) That the figures shown have been audited and that the auditor guarantees they're correct; or

(b) That the statement portrays what the company's financial condition will be after the new financing is completed; or

(c) That the statement is included in the prospectus as a formality required by law?

2. Government economists predict a gross national product (GNP) of \$400 billion in 1957. Does the GNP figure represent . . .

(a) The total of all Government expenditures plus the national debt; or

(b) The value of all manufactured goods produced annually: or

# CAN YOU PASS THIS BUSINESS QUIZ?

- (c) The value of the output of all goods and services produced by the nation's economy?
- 3. A friend mentions that he has money in a common trust fund. Does this refer to . . .



"I just couldn't sleep from worrying, Doctor. I visited my sister Mary Sue a month ago ... you know, the one who lives in Savannah ... and her daughter Isabel had the mumps. I should never have gone there, pregnant the way I am ... I've been feeling all sort of blown up since I got back. Do you think my unborn child could have got the mumps ...?" Etc., Etc.

146 MEDICAL ECONOMICS · JUNE 1957

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(a) A form of open-end mutual fund; or

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- (b) A form of closed-end investment trust; or
- (c) A trust fund administered by a bank?

## Joint Title

- 4. You and your wife want to own your home jointly in such a way that it automatically passes to the survivor on the death of either one. To effect this, should your joint ownership be . . .
  - (a) Tenancy by the entirety;
  - (b) Tenancy in common?
- 5. If you buy a preferred stock that is cumulative and participating, does this mean . . .
  - (a) You're entitled to participate in cumulative voting for directors just as the holders of common stock are; or
  - (b) You may participate in the firm's growth by letting dividends accumulate and be automatically reinvested; or (c) You'll receive in future years the cumulative total of any dividends not paid when originally due; and you'll have a chance to participate in a special way in company profits by receiving more than the preferred's fixed dividend?

- 6. A corporation in which you own 10 shares wants to install a cumulative voting system for the election of ten members of the board of directors. Under this system, could you...
  - (a) Cast only one vote; or
  - (b) Either cast 100 votes for any one candidate or apportion 100 votes among any number of candidates; or
  - (c) Cast 100 votes, but only for a single candidate?

# **High Profits?**

- 7. A brochure outlining the financial status of a firm in which you plan to invest mentions that the company has a "current ratio" of 2-to-1. Does this mean...
  - (a) That this year's gross sales are expected to be twice as high as last year's; or
  - (b) That this year's net profits are currently twice as high as last year's; or
  - (c) That current assets (such as accounts receivable) are twice as high as current liabilities (such as accounts payable)?
- 8. There's been a good deal of talk lately about debentures. Is a debenture...
  - (a) A set of provisions accompanying a stock issue; or

# CAN YOU PASS THIS BUSINESS QUIZ?

(b) A specific kind of bond secured simply by the general credit of the corporation rather than by any of its tangible assets; or

(c) Any bond except a U.S. Savings Bond?

9. The president of a large corporation requests information about one of your former employes whom he's thinking of employing as his personal secretary. If your letter to him says, truthfully, that you fired her some years ago for petty thievery without, however, bothering to prosecute her, will you . . .

(a) Be open to an accusation of slander because there's no official police record of her action: or

(b) Be open to an accusation of libel since you put the defamatory facts in writing; or

(c) Be not liable for anything, since the facts are true and such a letter is privileged?

10. You own five \$1,000 cor- all the poration bonds. There's a rumor find, b that the company is planning to for if call (redeem) them before matur- prefer ity. If this happens, will you receive . . .

(a) Less than the face amount, opport

(b) More than the face amount; or

(c) Exactly the face amount?

# The Correct Answers

1. (b) Such a "proforma" statement is often prepared in connection with new financing or a projected merger.

2. (c) GNP is a widely accepted barometer of the nation's business activity. It's periodically reported by the U.S. Department of Commerce.

3. (c) Suppose a bank is trustee for 100 separate trust funds. Instead of investing the funds of each trust separately, it may pool all the money to form one large account. Each single trust then retains its identity; but by participating in the common fund, it gets the added advantage of greater diversification.

4. (a) Underthisarrangement full title to the property passes to the survivor without the need of a will. It's a common impression that this solves all estate

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problems. The truth is that such joint ownership may bring serious tax disadvantages when one of the owners dies. A good lawyer should always be consulted before putting title in joint names.

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5. (c) A preferred stock with all these privileges isn't easy to find, but it may be worth hunting ing to for if you're in the market for a natur-preferred.

6. (b) Cumulative voting thus offers minority stockholders the nount; opportunity to help elect one or more of the directors.

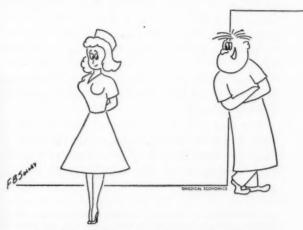
face 7. (c) This is also known as the "working capital" ratio. How

large the ratio should be depends mainly on the type of business the company is in.

8. (b) Such bonds often have added features to make up for the fact that they are unsecured by property. Some debentures, for example, are convertible into shares of common stock.

9. (c) Such a communication is privileged. You could not be held liable for damages unless it were proved that you had malicious intent.

10. (b) The company pays you a slight premium for exercising its right to pay off its obligations ahead of time.



"Say, Miss Perkins, when was your last physical?"



# Office Ownership: IsIt V

It's no cheaper than renting. But it nearly always results in a more rewarding medical practice

By Henry C. Black and Allison E. Skaggs

If you're ever going to build your own office, there's a right time to do it. But few doctors have worked out the timing as neatly as a young Michigan G.P. we'll call Dennebrink.

In 1953, Dr. Dennebrink was called back into the Navy for his second tour of duty in six years. The call came just as his small-town practice was burgeoning into something big—too big for his rented four-room suite, too big for his single aide, almost too big for one M.D. to handle.

A bad break, you might say. But Dr. Dennebrink recognized it as a professional turning point and turned it to his advantage.

With only three weeks' notice, he lined up a locum tenens to hold his practice together while he was away. More than that, he lined up an architect to help him build—in absentia—an office that would really be worth coming home to.

THE AUTHORS head the professional management firm of Black & Skaggs Associates, which has headquarters in Battle Creek, Mich., and affiliates in ten states. They founded "PM-Battle Creek" in 1932.

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aggs es in Working around the clock, the architect had preliminary plans drawn before Dr. Dennebrink left. Contractors' bids were waiting for his approval when he came home on his first leave. Construction work went on while the doctor was serving at sea. By the time he was mustered out, in 1955, his practice prospects were twice as good as before the military interruption—thanks to the locum tenens and to the new office.

Today the \$35,000 building is jointly owned by Dr. Dennebrink and his erstwhile locum tenens, now promoted to the status of full partner. They practice there with four aides. They have three times as much space as they used to rent, and they pay three times as much to maintain it. But they handle more out-patients than does the 100-bed hospital located across the street! Professionally and financially, they're years ahead of where they would have been if Dr. Dennebrink hadn't recognized the right time to build.

How does a doctor recognize the right time to build? Well, as the above story suggests, there are two obvious professional prerequisites. Dr. Dennebrink didn't even consider building his own office until:

- After he'd become well established in practice locally and knew he wanted to make his career there.
  - 2. After he'd rented office space long enough to know

exactly what he wanted in the way of room arrangement and facilities.

Less obvious than these professional prerequisites are the financial ones. Here, too, as it happened, Dr. Dennebrink put first things first. He didn't think seriously about office ownership until:

3. After he'd bought enough life insurance to protect his family's future. (His first purchase had been a \$10,000 G.I. policy. He'd added another \$15,000 worth of term insurance, then \$20,000 in ordinary life.)

4. After he'd bought enough disability insurance to carry him through a prolonged period without earnings. (The policies he now carried would pay him \$500 a month for five years if illness forced him to quit practice.)

 After he'd established a permanent cash reserve for emergencies. (Dr. Dennebrink had set aside \$2,500 in a special savings account.)

6. After he'd become a homeowner. (His home still had a \$15,000 mortgage on it; but at least the cash payments, closing fees, and other large lump-sum requirements were out of the way.) 7. After he'd accumulated enough additional savings to cover the down payment on a new office.\* (In this case, the doctor had accumulated \$5,000—enough to meet cash requirements on the one-man office he'd originally had in mind. Later an inheritance enabled him to plan something more elaborate.)

## When to Decide

By the time he'd passed all seven of these check-points, Dr. Dennebrink was 38. At that, he was lucky. Most medical men don't pass them until their early forties.

Then, if they decide to build, they need to do it before they get far into their fifties. It's seldom advisable for an older doctor to shoulder the financial obligations of a new office. He probably won't get his money's worth out of it.

Thus the right time to build may be only a decade or so in the middle of a man's career.

Sometimes, of course, the right time never comes. More often, in our observation, the right time passes unnoticed. And that's too bad, missec happe

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<sup>\*</sup>Down-payment requirements and sources of mortgage loans are discussed in detail in "Need Money for a Medical Office?" MERI-CAL ECONOMICS, August, 1956.

bad, because it may mean a missed opportunity. Will this happen to you?

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Suppose you're approaching your middle years. Suppose you discover (perhaps just now) that the professional and financial signal lights have turned green. That's when you owe it to yourself to delve deeply into the key question about office ownership: Is it worth the cost?

### **Five-State Study**

To help you decide, we recently conducted a study of what 102 different doctors spent to build their own medical offices; what they now spend to maintain them; and whether they're better off than in rented quarters. The doctors are located in Illinois, Indiana, Michigan, Ohio, and Wisconsin. Their offices were all built within the last few years.

The results of our study? Well, averages for all offices surveyed aren't too indicative, since building costs vary so greatly by community size. Specific examples may well be a better yardstick—and you'll find twenty of them tabulated on pages 154-156.

Certain medians may also help you—for example, the medians for offices built in medium-size cities (20,000 to 250,000 population.) If you remember that costs run somewhat lower in small towns and somewhat higher in the great metropolitan centers, the following figures will give you a rough idea of what office ownership might cost you.

Cost of land: The typical solo doctor in a medium-size city paid \$3,000 for his lot. The typical two-man partnership paid \$5,022. Where three or more doctors banded together, their median land costs came to \$9,750 in all.

Construction cost: The typical one-doctor office in a medium-size city cost \$23,060 to build. The typical two-doctor office went up for \$37,408. Larger medical buildings varied so much in cost (from \$42,306 to \$109,-800) that the median doesn't mean much.

Operating cost: Annual maintenance for the typical one-doctor office in a medium-size city amounts to \$3,600. This includes actual outlays for heat, water, electricity, other utilities, repairs, cleaning, taxes, and insurance. It also includes standard allowances for depreciation and interest.

For the typical two-doctor of-

# 20 Examples of What It Costs to Build a Medical Office

Owner	Location	Cost of Land	Type of Building	Square Feet Of Finished Space	Construction	Construction Cost Per Square Foot
General practitioner	Village of 500	\$ 1,000	Cinder block	1,182	\$11,540	\$ 9.70
General practitioner	Village of 1,000	1,012	Cinder block	1,350	21,682	16.00
General practitioner	Town of 7,500	1,215	Prefab	800	8,597	10.60
General practitioner	Town of 15,000	4,000	Masonry veneer	1,450	17,953	12.40
General practitioner	Town of 15,000	4,882	Masonry veneer	1,800	30,268	16.80
Internist	Town of 17,500	1,000	Masonry veneer	1,288	21,630	17.00
Obstetrician	City of 30,000	3,000	Frame	086	23,060	23.10
Surgeon	City of 60,000	5,030	Masonry veneer	2,150	31,650	14.70
Internist	City of 100,000	1,200	Frame	066	28,400	28.70
Ophthalmologist	City of 125,000	2,000	Frame	1,200	27,910	21.50
Obstetrician	City of 175,000	3,000	Frame	1,100	17,000	15.50
Urologist	City of 250,000	5,000	Masonry	875	21,080	24.00
Two surgeons	Suburb of 1,500	1,553	Brick	2,400	42,306	16.80
Two G.P.s	Town of 8,000	1,365	Brick veneer	2,600	45,004	17.30
Two ophthalmologists	Town of 18,500	5,022	Masonry	2,226	37,408	16.08
Two G.P.s	City of 60,000	4,000	Masonry veneer	2,484	28,400	11.40
Three G.P.s	Town of 12,000	20,400	Brick veneer	2,600	52,300	20.00

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G.P., internist, dentist City of 60,000

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# 20 Examples of What It Costs to Maintain a Medical Office

Owner	Location	Type of Building	Square Feet Of Finished Space	Annual Operating Cost*	Annual Operating Cost Per Square Foot	Annual Annual Rental Operating Of Comparable Cost Per Quarters Per Square Foot Square Foot
General practitioner	Village of 500	Cinder block	1,182	\$ 2,719	\$2.30	
General practitioner	Village of 1,000	Cinder block	1,350	3,267	2.42	\$2.00
General practitioner	Town of 7,500	Prefab	800	1,320	1.65	
General practitioner	Town of 15,000 1	Masonry veneer		3,234	2.23	2.00
General practitioner	Town of 15,000	Masonry veneer	1,800	3,650	2.05	2.50
Internist	Town of 17,500	Masonry veneer		2,962	2.30	1.85
Obstetrician		Frame		3,750	3.84	4.00
Surgeon	City of 60,000	Masonry veneer	2,150	6,300	2.95	3.50

Annual operating cost includes expenditures for heat, water, electricity, other utilities, repairs, cleaning, maintenance, insurance, and taxes. It also includes allowances for depreciation (using the straight-line method in all cases) and for interest (using 5 per cent of the total investment for fair comparison).

[MORE ]

# 20 Examples of What It Costs to Maintain a Medical Office (Cont.)

Owner	Location	Type of Building	Square Feet Of Finished Space	Annual Operating Cost*	Annual Operating Cost Per Square Foot	Annual Rental Of Comparable Quarters Per Square Foot
Internist	City of 100,000	Frame	066	3,600	3.65	3.50
Ophthalmologist	City of 125,000	Frame	1,200	3,600	3.01	3.50
Obstetrician	City of 175,000	Frame	1,100	3,025	2.75	4.25
Urologist	City of 250,000	Masonry	875	3,107	3.78	3.75
Two surgeons	Suburb of 1,500	Brick	2,400	6,480	2.70	-
Two G.P.s	Town of 8,000	Brick veneer	2,600	7,222	2.78	2.50
Two ophthalmologists	Town of 18,500 Masonry	Masonry	2,226	6,088		
Two G.P.s	City of 60,000	Masonry veneer	2,484	6,210	2.50	3.00
Three G.P.s	Town of 12,000	Brick veneer	2,600	7,206		2.50
G.P., internist, dentist	City of 60,000	Masonry veneer	2,400	7,056		3.75
Three surgeons	City of 175,000 E	Brick and stone	3,116	13,314	4.30	4.25
Four obstetricians	City of 250,000	Masonry	3,700	15,468	4.18	3.75

\*Annual operating cost includes expenditures for heat, water, electricity, other utilities, repairs, eleaning, maintenance, insurance, and taxes. It also includes allowances for depreciation (using the straight-line method in all cases) and for interest (using 5 per cent of the total investment for fair comparison). fice, to \$ the able

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fice, annual maintenance comes to \$6,088. As before, figures for the larger buildings are too variable for comparison.

# Owning vs. Renting

There you have some typical costs of office ownership. Next question: How do these costs compare with the cost of renting similar quarters in the same community?

It's often said that owning is cheaper than renting. But our study doesn't bear this out. When you take proper account of depreciation and interest, you find that office operating costs fluctuate above and below local rental rates without showing any significant difference.

The last two columns of the table on pages 155-156 illustrate this, There are sixteen cases where it's possible to compare office operating costs with local rental rates. In nine of these cases, owners pay more per square foot; in seven cases, rentors pay more. The difference is seldom more than 50 cents per square foot per year.

But what do the owners get for their money? Here's where the advantages of office ownership begin to show up. Our study indicates that the doctor who builds his own office when the timing is right—and when he's competently advised—generally gets:

¶ A combination of location, layout, and facilities that's better suited to his practice than anything available for rent. The specialist can be close to his hospital; the G.P. can be close to where his patients live. In either case, better parking facilities make it easier for patients to visit the office. And better treatment-room facilities make it easier to handle them when they get there.

¶ Greater potential security for himself and his family. The doctor is protected against landlord trouble, loss of lease, loss of money put into leasehold improvements. The family is provided with a capital asset that may retain its value after the doctor's death—that may provide a good rental income if desired.

# **How Practices Grow**

What are these advantages worth in dollars and cents? Potential security is difficult to measure, but professional efficiency isn't. The difference a new office makes can be gauged fairly accurately by the volume of practice—the total business done—

before and after a doctor builds.

MEDICAL ECONOMICS tells us that doctors' incomes across the country have been rising at the rate of 5.5 per cent a year. This pretty well reflects the past experience of the 102 doctors we surveyed. Almost without exception, their practices were growing at the rate of 5 to 10 per cent a year before they built.

After they built, one-fourth of them reported no change from this normal rate of growth. But three-fourths of the doctors reported their practices began growing at an annual rate of 15 per cent, 20 per cent, or even 25 per cent—and in a few cases, 50 per cent. Some of these substantially higher growth rates have held up for as long as five years.

Think what this means: By in-

vesting perhaps \$7,500 cash in a custom-designed office, the typical doctor has stepped up his earnings by that amount the first year—and by more each year thereafter. Yet he practices with more security, less effort, and about the same operating costs as he'd pay for the rental of equivalent space.

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As the major finding of our study, this calls for further demonstration. With identifying details disguised, here's how five different offices happened to get built—and what they mean professionally and financially to their owners today. The offices are at five different price levels: roughly \$10,000, \$20,000, \$30,000, \$40,000, and \$50,000. So one of these case histories may mirror your own future.

# \$10,000 Office for a G.P.

Case A: Right after World War II, a young G.P. hung out his shingle in a small Illinois town. He rented three rooms on the first floor of a converted residence. By 1953, he had a good practice—but it wasn't growing.

Then a local druggist offered

him a choice piece of property in the very center of town. On one side was the drug store; on the other, the local post office; across the street, the bus station. "The lot's yours for \$1,000 if you'll build there," said the druggist. The doctor decided to do it. Six months later, he had a modest cinder-block building with 1,182 square feet of floor space. Cost: a rock-bottom \$9.70 per square foot, or \$11,540 in all. He paid one-third cash and arranged a mortgage with the druggist for the rest.

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What did he get for his investment? A well-laid-out working space of eight small rooms instead of the three large ones he'd rented. A location more easily accessible to people who lived outside the town. A combination of advantages that couldn't be rented locally at any price.

The effect on his practice volume? Here are his figures on total business done during the year before he built (in italics) and the three years afterwards:

 1953 practice volume . . \$35,017

 1954 practice volume . . 47,300

 1955 practice volume . 50,018

 1956 practice volume . . 54,215

That's a 55 per cent increase in



"It seems he was drinking wine out of some girl's shoe—when he swallowed the arch support."

### OFFICE OWNERSHIP: WORTH THE COST?

total business, spread over three years. Yet office ownership costs this doctor just 5 per cent of his gross earnings—exactly the same percentage he used to pay to rent an office.

# \$20,000 Office for a G.P.

Case B: For five years, an Indiana G.P. practiced in two rooms upstairs over the telephone company. His X-ray, his diathermy, and most of his professional tools were jammed into

a single consultation-examination-treatment room. "The thing that finally got me down," he recalls, "was waiting for patients to dress while other patients were waiting outside on the stairs."



"Hey, Mabel-our Latin menu!"

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He was given a chance to rent better space downtown. This drove him to some hard thinking and to a different location in the residential district. He bought a lot across from the new high school, then put up a \$21,682 building. It was financed entirely within his family (some newly inherited money plus a private mortgage).

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Overcompensating for his previous cramped quarters, the doctor put in four separate treatment rooms. Two weren't used much at first. But as new patients began coming in from the neighborhood, he found that he needed the space. He hired a second aide, then a third, and managed to keep up.

The new patients sent his prac-

tice volume soaring. So did a long-overdue increase in fees, which the doctor now felt justified in making because of the new office facilities.

His total business before he built (in italics) and immediately thereafter:

1954 practice volume . . \$30,075 1955 practice volume . . 39,111 1956 practice volume . . 58,005

Office ownership costs this man \$2.42 per square foot per year. He could rent comparable quarters downtown for \$2.00 per square foot per year. But he couldn't rent anything in the fastgrowing residential district—the place where this doctor has virtually doubled his practice in just two years.

# Internist's \$30,000 Office

Case C: A roomy, gloomy rented office downtown was this Michigan man's base of operations. Patients' parking was his chief problem. The old office building he practiced in was surrounded by parking meters (time limit: 30 minutes). The diagnostic tests that he specialized in usually took longer than that.

The break came when the landlord raised his rent to \$300 a month. "For that much," the doctor told him, "I could practice in something better than this mausoleum." Eventually he proved it-though he had to build the proof himself. [MORE▶

## OFFICE OWNERSHIP: WORTH THE COST?

The site he picked was strategically located between the business and the residential districts. His first words to the architect were: "I want a parking lot for twelve cars."

# **Expensive Space**

The office that went with it had less floor space than he'd had before. But that was just as well, since construction costs were sky-high: \$28.70 per square foot, or a total of \$28,400 for 990 square feet. The doctor paid half in cash and arranged a bank loan for the rest.

Better parking, better location, better atmosphere—these were almost the only things the doctor got that he didn't have before. But they had an immediate effect on his practice volume. His total business during the year before he built (in italics) and afterwards:

1955 practice volume . . \$36,100 1956 practice volume . . 44,450

"It's worth building your own office just to get better parking," this doctor says today. For increasing numbers of downtown doctors, that's the simple truth.

# Two Surgeons' \$40,000 Office

Case D: An Ohio partnership rented space in a converted store. It was long and narrow; the two surgeons must have walked three miles every day just going up and down the corridors. And they had to drive three miles through heavy traffic every time they visited their hospital-which was often several times a day.

The hospital was a new one, off by itself in a small suburb. There was nothing to rent nearby. Eventually the two surgeons decided they'd be better off building there. They bought a lot 100 yards from the hospital and put up a \$42,306 ranch-style office. The senior partner paid for the whole thing, then took a mortgage from the junior for his share.

They soon found that they had more floor space (2,400 square feet) than they really needed. They found, too, that their location was coveted by other physicians on the hospital's staff. So today 1 part-tin come is mainte buildin

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today they rent out space on a part-time basis; and the rental income is enough to pay their cash maintenance costs on the whole building.

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### **Increased Volume**

Meanwhile, easier access to the hospital has meant more hospital work for the two surgeonpartners. Their practice volume shows it. Here are their figures for the year before they built (in italics) and the year just after: 1955 practice volume . . \$69,333 1956 practice volume 80,015

As ordinarily figured, office ownership costs these two surgeons \$2.70 per square foot per year. But when you take their rental income into account, you find that their real cost is only half that. Under such circumstances, owning can be substantially cheaper than renting.

# \$50,000 Office for Three G.P.s

Case E: Two Wisconsin G.P.s practiced in the basement of a large boarding house. Their practice was getting too big for them to handle, so they took on a third man. Then they realized that their problem wasn't so much manpower as space. There was just one examining room per doctor. Patients often had to wait an hour or two to be seen.

The doctors tried to buy the whole boarding house, but the owner wouldn't sell. There was just one other prize location in town: a large lot right next to a new shopping center. The price tag was a breath-taking \$20,400.

The doctors took a deep breath —and bought it.

By raiding their bank accounts and borrowing from relatives, the three doctors scraped up enough cash for the down payment on a medical building fit for this prize spot. In the end, they got 2,600 square feet of floor space. They got three examining rooms apiece. They got a parking lot for thirty-five cars. And they got a bill for \$52,300—most of it paid by the insurance company with which they'd arranged a mortgage.

Was this splurge worth-while? So far, it seems [MORE ON 276]



# How Long Before You're Safe from Suit?

Patients sue doctors on at least five different grounds. Here's the statutory time limit on each

By William N. Jeffers

If a patient shows signs of wanting to sue you for malpractice, how long are you in legal jeopardy? How long can he delay filing suit before the law automatically puts you out of his reach—and makes it safe for you to remove his folder from your bulging files?

The answer depends, of course, on where you practice. All states and the District of Columbia have their statutes of limitation; and—as you can see from the tables on the following pages—nearly all the statutes are different. Obviously, these differences make it vitally important that you know the law in your state.

In only seventeen states does the law refer explicitly to physicians' malpractice or professional liability. In the rest of the country, such suits are governed by statutes applicable to torts in general, broken contracts, or assault and battery. (There's an increasing tendency for patients to claim assault and battery instead of professional malpractice, as in the case of an unauthorized operation.)

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All but three states have wrongful-death statutes. These are invoked in deaths allegedly caused by the physician's negligence or lack of skill; hence these time limits too can be important to you.

Besides knowing the time limits, you need to know what can stop the clock on them. The usual stopper is youth. In forty-four states, if the injured party is a minor, the statute doesn't start to run till he comes of age.

Another stopper is alleged fraudulent concealment. Suppose a surgeon left a sponge in a patient but said nothing about it. If there's any evidence he knew it was there, some states and the District of Columbia would hold that the statute of limitation wouldn't begin to run until the patient discovered the injury—or, using common sense, should have.

In five states, the time limits don't begin to run until the injury is found, or should have been, in any case fraudulent concealment or no fraudulent concealment.

In most states, the time limits for patients' suits against doctors are shorter than those for doctors' suits against patients. This is to your advantage if you ever find it necessary to take a delinquent debtor to court. By waiting until the patient's time for suing has passed, you'll ordinarily be safe from a malpractice counterclaim.

The charts on the next few pages, based on data recently compiled by the A.M.A. law department, convey the gist of the statutes of limitation in all states and the District of Columbia. 

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# Time Limits (Years) of Statutes of Limitation On Various Charges Against Physicians

		Brunch of, Oral Cantons	Brough of Written Gentweet	Associate and Battery	V <sub>Dred</sub> ()
Ala.	2				2
Ariz	2	3	s and 6		7
Ark.	2				2
Calif.	1	2		1	1
Colo.	2	3	3	1	2
Comn	1-4	8	6		
Del.	1	3	3	A DES	203
D.C.	11.3	3.	3	10.	1
Fla.	3	3	3	2	-2
Ga.	2	•	6		2
Idaho	2	4	5	·2	2
III.	2	5	10		1
Ind.	2				2
iowa	\$ 12-V				2
Kan.	2	3	5	1	2
Ky.	1	5	15	1	1

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# When the Time Limits Specified in the Statutes Of Limitation Start to Run

	Statutes Den't Clearly Specify	When Injurious Act Is Committed	When Patient's Treatment Ends	When Doctor- Patient Relations End	When Injury Is Discovered —Or Should Have Been	When Minor Patient Comes of Age
Ala.					x	x
Ariz.		x				x
Ark.		x				x
Calif.					x	x
Colo.		x				x
Conn.		x				
Del.		x				
D.C.	x					x
Fla.	x					
Ga.		x				x
Idaho		x				x
m.		x				x
Ind.		x				x
Iowa		x				х
Kan.		x				x
Ky.		x				x

[MORE

#### TIME LIMITS (YEARS) OF STATUTES OF LIMITATION (Cont.)

	Malpractice	Breach of Oral Contract	Breach of Written Contract	Assault and Battery	Wrongful Death
La.	1	10	10		1
Me.	2	6	6	2	2
Md.	3	3	3	1	11/2
Mass.	2			2	2
Mich.	2	6	6	2	
Minn.	2	1		2	3
Miss.	6	3	6	1	6
Mo.	2 .	5	5	2	
Mont.	3	5	8		3
Neb.	2	4	5	1	2
Nev.	4	4	6	2	2
N.H.	2	6	6	P. Carlot	2
N.J.	2	6	6		2
N.M.	3	4	6		3
N.Y.	2	6	6	2	2
N.C.	3	3	3	1	2
N.D.	2	6	6	2	2

#### WHEN THE TIME LIMITS START TO RUN (Cont.)

	Specify	Act Is Committed	Patient's Treatment Ends	Patient Relations End	Injury Is Discovered Or Should Have Been	Minor Patient Comes of Age
La.		3		733	x	
Me.	x	ž.		25 2 2 27	W. W. C	1X
Md.			F. 199	-	x	x
Mass.		X :				x
Mich.			1-1 1	x	C	x
Minn.				x		x
Miss.	x	1. 88		P. Sec. 1		x
Mo.			x		ę.	x
Mont.		x	-			x
Neb.			x.			x
Nev.	x	*.* *				x
N.H.	x				1000	X
N.J.		X		E Service		x
N.M.	x	-	1			. x
N.Y.		\$ <b>x</b> −∞				. x
N.C.	1	x -				x
N.D.	\$10 mar. 1				×	x [MORE

MEDICAL ECONOMICS · JUNE 1957 169

#### TIME LIMITS (YEARS) OF STATUTES OF LIMITATION (Cont.)

	Malpractice	Breach of Oral Contract	Breach of Written Contract	Assault and Battery	Wrongful Death
Ohio	1	6	15	1	2
Okla.	2	3	5	1	2
Ore.	2	6	. 6	2	Ker I
Pa.	2	6	6	2	1
R.I.	2	6	6		2
S.C.	6	6	6	2	6
S.D.	2			2	3
Tenn.	1	6	6		01
Tex.	2	2	4		2
Utah	4	4	6	1	2
Vt.	3	6	6	3	2
Va.	2	3	5		1
Wash.	3	3	6	2	3
W.Va.	1	5	10		2
Wis.	6	6	6	2	2
Wyo.	4	8	10	1	2

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#### WHEN THE TIME LIMITS START TO RUN (Cont.)

	Statutes Don't Clearly Specify	When Injurious Act Is Committed	When Patient's Treatment Ends	When Doctor- Patient Relations End	When Injury Is Discovered —Or Should Have Been	When Minor Patient Comes of Age
Ohio				. x		<b>x</b>
Okla.		x				x
Ore.		x		A. 12		x
Pa.		x				x
R.I.	x		1000			x
S.C.	x			13 15 (48) 13 15 16 16 16		x
S.D.	x					x
Tenn.		x			HAME.	x
Tex.		x				x
Utah			X			x
Vt.		. x				x
Va.	~ <b>x</b>			2316		x
Wash.		x				x
W.Va.		x				x
Wis.		x				x
Wyo.	x					x
						EN

MEDICAL ECONOMICS · JUNE 1957 171



# WHEN CONSTIPATION WAS A PROBLEM to the Egyptians—

Imhotep, the "first physician," discovered castor oil (2850 B.C.), which was later described in the Ebers Papyrus. Purging was not outmoded until the present century.

# WHEN ATONIC CONSTIPATION IS A PROBLEM toda

Doxinate with Danthron is provided as a brown, soft gelatin capsule containing 60 mg. dioctyl sodium sulfosuccinate and 50 mg. Danthron (1,8-dihydroxyanthraquinone).

Average dose—one or two capsules at bedtime. Supplied in bottles of 30 and 100 capsules.

LLOYD BROTHERS, INC.

When stubborn chronic constipation exists, dry feces and weakened bowel activity require both fecal softening and mild peristaltic stimulation. Doxinate with Danthron provides the effective fecal softening of Doxinate and the gentle laxation of Danthron.

for soft stools gently stimulated to evacuation

# DOXINATE WITH DANTHRON

the original fecal softener combined with gentle laxation

Doxinate with Danthron relieves the colonic inactivity in the atonic constipation of the geriatric patient as well as in the temporary atonic constipation of the hospitalized or inactive younger patient. The gentle stimulus offered by the reduced dose of 1,8-dihydroxyanthraquinone (Danthron) is confined to the large intestine.

#### DOXINATE WITH DANTHRON:

Corrects the tendency to fecal dehydration—the primary cause of functional constipation.

Assists the weak, atonic bowel in fecal elimination.

Permits complete elimination with significantly reduced peristaltic stimulation.

Useful to initiate therapy in patients with the laxative habit.

MEDICAL ECONOMICS - JUNE 1957 173

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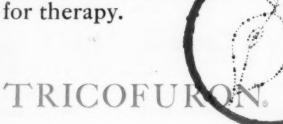
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S, INC.

Even stubborn trichomoniasis yields...

because Tricofuron is effective during menstruation,

the critical time for therapy.



Recurrences of trichomoniasis "are most likely to follow the menstrual period."<sup>1</sup>

"Over and over again today patients are seen with what is said to be an intractable, treatment-resistant Trichomonas infestation, but history-taking often reveals that such patients have never had treatment prescribed during any menstrual period."2

Menstrual blood in the vagina "forms an excellent medium for the rapid multiplication of T. vaginalis" and "lowers the acidity of the vagina and hence there is a tendency to recrudescence [of trichomoniasis] at that time."

Tricofuron is powerfully trichomonacidal "even in the presence of vaginal debris and menstrual blood."<sup>3</sup> For 44 of 48 patients: lasting cure was obtained with a single course of Tricofuron therapy,<sup>3</sup>

Vaginal Suppositories — for home use—each morning and night through one cycle, including the important menstrual days. Contain 0.25% Furoxone\* (brand of furazolidone) in a water-miscible base. Box of 12, each sealed in green foil.

Vaginal Powder-for office use-applied by the physician at least once a week, except during menstruation. Contains 0.1% Furoxone in an acidic powder base. Bottle of 30 Gm.

References: 1. Bernstine, J. B., and Rakoff, A. E.:
Vaginal Infections, Infeatotions and Discharges, New
York, The Blakiston Company, Inc., 1953, p. 235.
2. Overstreel, E. W.: Arizono M. 10,383, 1953.
3. Schwartz, J.: Obst. izono M. 10,383, 1953.
4. Crossen, R. J.: Discose of Women, St. Louis,
The C. V. Mosby Company, 1953, p. 292.

EATON LABORATORIES

NORWICH, NEW YORK

Nitrofurans-a new class of antimicrobials-neither antibiotics nor sulfonamides

174 MEDICAL ECONOMICS · JUNE 1957



## Why Some Collection Letters Don't Collect

Often it's because they contain phrases that rub people the wrong way. Here are nine to avoid

By James Fuller

Even in collection letters recommended by experts, you'll find many a psychological booby-trap. I mean a word, a phrase, or a sentence that can rub the debtor the wrong way, thus making him less inclined to pay up.

Some letters abound with such phrases. If you doubt it, take a look at the following examples. They stem from collection letters in actual use in medical offices today:

"I feel sure that you must have overlooked my statement..."

This is a familiar approach, but bristling with insincerity. Its variations are no more convincing—for example, "You've probably mislaid my last bill." Or

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#### ING...TH

outmoding older concepts

IN THE FULL RANGE OF AGITATED MENTAL AND EMOTIONAL DISTURBANCES FROM SEVERE PSYCHOSES TO ANXIETY AND TENSION STATES, age-old methods of merely sedating the anxious or of managing hospitalized patients by heavy sedation or physical restraints have been largely supplanted by the older tranquilizers. Certain of the latter agents in turn are due to be superseded by TRILAFON, a new all-purpose tranquilizing agent which offers greater potency combined with increased flexibility and an adequate

margin of safety in the recommended dosage ranges.

with

NEW

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Packa 16 mg

#### LIANGETRANQUILIZER

with markedly enhanced potency

# Trilafon

equally valuable in all degrees of psychic disorder responsive to tranquilizing therapy

AGITATED HOSPITALIZED PSYCHOTICS

AMBULATORY PSYCHONEUROTICS

ANXIETY AND TENSION STATES

- potency increased 5-fold over chlorpromazine
- uniquely high therapeutic index—10 times higher than chlorpromazine in animal studies
- · jaundice notably infrequent in studies to date
- · significant hypotension virtually absent
- · no agranulocytosis reported
- · skin photosensitivity neither observed nor elicited experimentally
- · nasal congestion uncommon
- · mild insomnia and motor restlessness infrequent

#### unexcelled also as a potent antiemetic

Dosage: For specific information consult Schering literature.

Packaging: TRILAFON Tablets: 2, 4, and 8 mg., bottles of 50 and 500;
16 mg. (for hospital use), bottle of 500.

Schering

\*P.H. 79-2-33

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#### WHY SOME LETTERS DON'T COLLECT

"Perhaps this overdue account has simply slipped your mind."

Why are these openings psychological booby-traps? Because the patient, as well as the doctor, knows they're phony. After having already opened two or three monthly bills, the average person is generally well aware of his obligation. At any rate, it's much more complimentary—and productive-for the physician to assume so.

"In order to meet my own obligations, I must request prompt payment for my services . . ."

The only valid reason for a debtor to pay up is that he owes the debt. When a physician tries to stir up sympathy for his financial problems, he's generally paddling up a dry creek. Worse, he's likely to irritate the patient with this tear-jerker approach. And irritation seldom generates checks.

"I've been checking over Doctor's accounts and find that you haven't yet sent us any payment. Would you mind helping us out? . . . "

What does this secretary think

ideal... And when dermatoses are in bloom

# **NEO-MAGNACORT**

topical ointment

### NEOMYCIN + the first water-soluble dermatologic corticoid

outstanding availability, penetration, therapeutic concentrations and potency - without systemic involvement. In 1/2-oz. and 1/6-oz. tubes, 0.5% neomycin sulfate and 0.5% ethamicort (MAGNACORT).

### for inflammation without infection MAGNACORT topical ointment

In 1/2-oz, and 1/6-oz, tubes, 0.5% ethamicort (hydrocortisone ethamate hydrochloride).



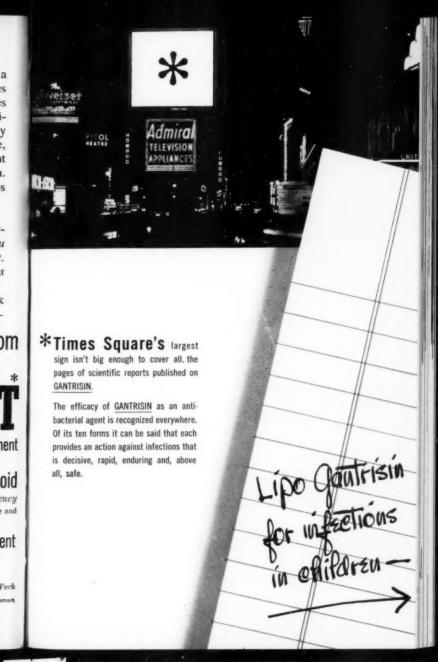
PFIZER LABORATORIES (Pfizer) Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

\* Trademark

178 MEDICAL ECONOMICS - JUNE 1957

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### LIPO GANTRISIN

'ROCHE'

#### provides therapeutic blood levels of time-proved Gantrisin around-the-clock—with only two doses daily

#### DESCRIPTION:

Lipo Gantrisin should be considered for use in many systemic and urinary tract infections because it provides:

- the time-proved wide-spectrum antibacterial action of Gantrisin in a stable, free-flowing homogenized emulsion
- 2. convenience of the rapeutic blood levels for 24 hours with just  $\underline{\mathsf{two}}$  daily doses
- 3. delicious taste that assures wide acceptance by children and adults
- no need for forced fluids...no danger of renal blocking or secondary fungus growth

#### INDICATIONS:

Systemic and urinary tract infections due to streptococci, staphylococci, pneumococci, H. influenzae, K. pneumoniae, meningococci, E. coli, B. proteus, B. pyocyaneus, A. aerogenes, B. paracolon and Alcaligenes fecalis.

#### DOSAGE:

Children:	teaspoonfuls every 12 hours	
20 lbs	1	CAUTION:
40 lbs	11/2	The usual precautions in sulfona
60 lbs	2	mide therapy should be observed
80 lbs	3	
Adulto	A	

#### SUPPLIED:

Lipo Gantrisin Acetyl, containing 20 per cent Gantrisin (1 Gm per 5 cc in the form of Gantrisin Acetyl), in a palatable, readily digestible homogenized emulsion that prolongs the action of the drug. In bottles of 4 and 16 oz.

Lipo Gantrisin® Acetyl - brand of acetyl sulfisoxazole



HOFFMANN - LA ROCHE INC . NUTLEY . N. J.

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cause action she's doing—soliciting a contribution to the Society for the Support of Dr. Smith? Such pleading puts the physician in a weak, defensive position. It sacrifices his dignity and invites contempt.

"When the courtesy of extended payment was originally given you, it was based on my confidence in your honesty..."

This rates as a booby-trap because it invites the following reaction: "So I'm dishonest, am I? Well, if *that's* what he thinks..." And into the wastebasket goes the letter.

Moral: Don't cast aspersions
—even indirect ones—on any
debtor.

"I am disappointed that you have failed to make a remittance..."

If you really want to annoy a person, just tell him that he's let you down. People don't like to be reminded of their failures in so



"Friends, do you have trouble hearing my voice?"

### When

# Temptation



#### COLLECTION LETTERS

many words. When they are so reminded, they're even less likely to cooperate with you.

"Unless I hear from you within the next week, I will be forced to take drastic action . . ."

What drastic action? The threat is almost meaningless because it's so vague. As a rule, ultimatums are best avoided. They don't give the debtor enough chance to save face.

"I didn't fail you when called upon to render service. Why should you fail me? . . ."

There's that suggestion of failure again. In addition, this gambit plays up the "I" angle (instead of the "you" angle) and sentimentalizes it. Better leave that to Dr. Kildare.

#### Tear-Jerkers

This little exercise in applied psychology is one that even the so-called experts have been slow to learn. One collection agency actually recommends phrases like these:

"I have given you the best within my power . . ."

"The time spent in writing you might better be used in saving another human life . . ."

Patients aren't dumb! They

180 MEDICAL ECONOMICS - JUNE 1957

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know how much interest the physician displayed in their case; and if it's any less than they expected, this approach may rate as the biggest psychological booby-trap

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When you come right down to it, a collection letter needs just three things:

1. A brief reminder of the amount owed, along with a direct request for payment.

2. An appeal to the debtor's pride and self-respect, which are the mainsprings of human behavior.

3. A sincere but informal writing style, as if you were simply talking to the person.

If you stick to the friendly, man-to-man approach—"I know you mean to pay"-you'll get results. And, just as important, you'll keep the patient's goodwill. END



... curb her appetite with

(Methamphetamine Hydrochloride, Abbott)



MEDICAL ECONOMICS - JUNE 1957 181



# Are You Training Future Competition?

If you take on an M.D. assistant, it's sensible to protect your practice with a restrictive covenant

By Andrew A. Sandor, M.D., LL.B.

When Harry Turner, fresh from interne training, joined forces with Dr. George Brooks, it seemed the beginning of a long and fruitful association.

To the elderly doctor, the young man was a godsend. He was competent and quick to learn. Patients liked him from the start. In time, the practice would be his and Dr. Brooks could retire with the knowledge that his patients were in good hands.

But a year later, things were less rosy. The two men disagreed over their partnership contract. Feelings grew more and more strained. Eventually, Dr. Turner left and set up a practice of his own in the next town. With him went many of the old doctor's patients.

After due warning, Dr. Brooks filed suit. He charged his former assistant with violating the terms of their original contract, by which Dr. Turner had agreed, if they parted company, not to practice within a radius of 100 miles.

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restores vitality

# THERACE BRIN

for a really vigorous multiple-vitamin regimen



DISTINGUISHED MEMBER OF THE Lilly FAMILY OF VITAMINS

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#### TRAINING FUTURE COMPETITION?

Was this unreasonable restraint of trade?

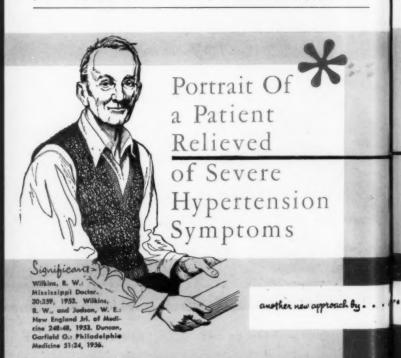
Young Dr. Turner argued that it was. The court ruled otherwise. The contract, it said, was voluntary and valid; the practice of a physician often covers an area larger than the 100 miles in question. Harry Turner was forced to move.

#### What the Law Requires

No court will deny the right of a doctor to practice where he pleases. Yet any doctor can legally restrict his own right to practice by a contract with another physician. To stand up in court, the contract need merely be reasonable and not contrary to public policy.

#### Why Help a Rival?

Such contracts between doctors are fairly common. The motive behind them is clear. No physician in his right mind wants to train a potential rival. When he takes on an assistant, he entrusts the new man with intimate details of his practice. He gives him the benefit of his hard-earned knowledge and skill. He provides him with patients.



Small wonder that he wants to protect himself.

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With a reasonably-worded agreement to restrain the other doctor from competing with him, he can generally feel safe. If the assistant pulls out and opens an office within the forbidden zone, he has deliberately violated their pact and the courts will support the injured ex-partner.

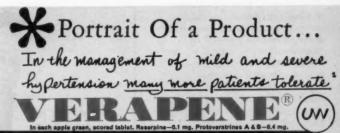
#### Can You Restrict Patients?

Sometimes, though, there are fine distinctions. For example: What if the departing physician sets up outside the prohibited area but gets two or three patients living inside it? Must he give them up?

#### What About House Calls?

An Ohio doctor found himself up against this very poser. His contract prevented him from establishing himself within five miles of his former location. His new office was well outside that range.

But occasionally he was asked to make some calls in the forbidden territory. The court held that to restrain him from entering the area for such cases would



SUBJECTIVE improvement is prompt and marked. Patients say they feel better.

DISTURBING SYMPTOMS such as headache, dizziness, tinnitus, disappear rapidly.

THE CHARACTERISTIC EFFECT of Protoveratrines A & B is enhanced by combining with reserpine, reducing the dosage requirements.

PATIENTS who are receiving reserpine respond more favorably to veratrum alkaloids. Many more patients tolerate the two drugs in combination, as response can be produced with dosage below usual limits of tolerance.

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Style-Everything's enclosed in a streamline casing finished in soft decorator colors . . . Coral, Green or Silvertone.

Simplicity—A cinch to run! The only double-shell autoclave with a single control for everything.

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136 MEDICAL ECONOMICS · JUNE 1957

#### TRAINING A RIVAL?

be unreasonable. The plaintiffs demand for issuance of an injunction against him was refused

#### Definition Needed

Failure to define distances precisely may also cause trouble. In a Pennsylvania case, the limit had been set at fifteen miles. The doctor opened his office twelve miles away as the crow flies. But the court interpreted "within a radius of fifteen miles" to mean fifteen miles by the shortest road -not by air. Figured this way, it was a little more than fifteen miles from the old to the new of-



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Parenzyme has been used successfully as an adjunct in severe pulmonary diseases (including bronchial asthma, emphysema, bronchiectasis) to loosen inspissated mucus plugs even when other recognized therapy has failed.1.2 "The uniformity of response of these patients [25] was striking." X-rays of

asthmatics show "dramatic improvement" in densities and truncal markings and confirm subjective findings of relief.2 Copious expectoration within 1-3 days of treatment was followed by decrease of dyspnea.2 For relapses, repeated courses of Parenzyme were as effective as the first one.2

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provides the proven therapeutic efficacy of Parenzyme in a new aqueous menstruum. Parenzyme Aqueous offers these advantages:

- · minimal pain on injection
- · no reactions due to oil sensitivity
- minimal local tissue reaction
- · easier to inject
- easier to clean needles and syringes.

Dosage: Inject intragluteally 1 ml. (5 mg.) daily for first week; 2 to 3 times weekly for 2nd and 3rd weeks; I time weekly for 4th week. Then alternate 2 weeks' rest periods with repeated 4 weeks' courses as needed.

Supplied: New Parenzyme AQUEOUS and Parenzyme in oil in multiple-dose vials.

References: I. Golden, H. T.: Delaware M.J. 26:267, 1954. 2. Silbert, N. E.: Dis. Chest 29:520, 1956.

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Changer, metal magazines each
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projects slide, stores it, and automatically
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#### TRAINING FUTURE COMPETITION?

fice. So the suit was dismissed.

Is the public harmed by these contracts between doctors? Most courts take a lenient view. In a Texas case, for instance, the judge said: "The public will not be hurt by such an agreement, since every other physician and surgeon of equal competence is at liberty to practice the same profession within the same limited territory."

#### **Public Interest**

Usually, it's the defending physician who poses the public-interest question. In a Kentucky

case where this happened, the court held that there were ample physicians in the community for the citizens' medical needs. No monopoly, it asserted, would result from upholding the contract.

#### Restraint of Trade

Rarely is restraint of trade itself a question. Most courts ask simply: Is this restrictive covenant reasonably necessary to preserve the goodwill or interests of the party in whose favor it is drawn? The answer, in most cases, is yes. But it's worth a double-check.

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- Fees for service, you might call these awards. Fees for what service? For distilling something valuable out of your practice-connected experiences and putting it in writing for the benefit of doctors everywhere. Your contribution can be either an article or an article idea.
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- Your article idea will have the best chance of winning if it's (a) between 100 and 300 words long; (b) specific rather than general; and (c) detailed enough so that our editors will understand exactly the economic, professional, or personal problem you have in mind.
- Entries must be postmarked no later than Dec, 31, 1957, and addressed to Awards Editor, MEDICAL ECONOMICS. Oradell, N. J. Manuscripts should be typed, double-spaced, on one side of the paper only, and accompanied by a self-addressed envelope and return postage.

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### 'Cytomel' in hypometabolism...

PATIENT: R.A., a 56-year-old male, exhibited a "deep-seated" asthenia. He was somnolent and slow in his movements. His weight had increased 18 pounds in three years. He showed facial edema, particularly of the eyelids, bilateral exophthalmos, yellowish skin. Pulse was slow—thyroid not palpable. BMR was low. Uptake of radioactive iodine by the thyroid gland was very low. Total serum cholesterol was normal.

DIAGNOSIS: Hypothyroidism.

**TREATMENT:** 50 mcg. of liothyronine (L-triiodothyronine) daily. **RESULTS:** By the 9th day, marked improvement in the clinical condition was observed. The patient threw off his customary apathy and became ambulatory. After 16 days of treatment, BMR had risen from -12% to +8% and the heart rate from 60 to 80/min.; serum cholesterol remained normal; weight had fallen from 238 to 227 pounds.



#### He Practices in a 'Museum'





When a new patient enters the Chicago office of Dr. Charles W. Olsen, he's in for a surprise. The place isn't really a museum, but it looks like one. Some of the things the observant patient can examine while waiting his turn to be examined:

¶ An assortment of Aztec pottery.

¶ A collection of Egyptian beads.

¶ Relics of the great Chicago fire.

¶ A bust of Lincoln.

¶ A clock from the home of Clarence Darrow.

¶ A cane and stickpin that belonged to John Wilkes Booth.

Dr. Olsen's hobby is collecting things, and he houses his finds at the office. Very much the generalist in his gathering interests, he doesn't limit himself to particular types of items. But he does have a special liking for letters and relics of famous persons. An entire room in his office is devoted to Lincoln. This Hami exam

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The vesicopustular eruption on both palms with associated hyperhidrosis was similar to eruptions in 1950 and 1954. Eruption cleared in 14 days with no recurrence.







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# The Truth About Unnecessary Operations

Who are the doctors who do needless surgery and why are they able to get away with it?

By LeMon Clark, M.D.

I've been thinking about unnecessary operations lately. And I've come to this conclusion: The small percentage of doctors who knowingly do needless surgery get away with it—prosper from it, in fact—because unnecessary operations do cure many sick people temporarily.

Once in a while, removal of a normal organ—an apappendix, an ovary, even the gall bladder or the uterus—is justified. Suppose, for instance, your patient has a pain in the lower right abdomen. You make all the necessary tests. You can't honestly say it's an inflamed appendix. But you can't say it isn't, either. In such a case, you may justifiably operate and remove what a courageous pathologist may later report to have been a normal appendix.

That's a lot different from a truly unnecessary operation, performed by the knife-happy surgeon who scorns

Copyright, 1957, by Medical Economics, Inc., Oradell, N.J. This article may not be reproduced, quoted, or paraphrased in whole or in part in any manner whatsoever without the written permission of the copyright owners. adequate diagnostic studies beforehand. Why does he operate? For \$250 or more, that's why.

One of my young G.P. friends was complaining the other day about what it meant to practice in the same town as such a surgeon. One of the G.P.'s patients, a 15-year-old girl, had had three attacks of intermenstrual pain. These always occurred midway between her menstrual periods. There was no muscle spasm, no tenderness over the appendix, no increase in the white blood count —in other words, no evidence of appendicitis.

My friend had seen the girl in three attacks. He had carefully explained to her and her mother that the pain was due to ovulation. But on the fourth attack the mother took her daughter to the Great Surgeon.

Into the hospital went the girl.
Out came her appendix.

The family were told it had been a very bad appendix and that she'd been operated on just in time. The pathologist's report didn't call it "bad," though. It called it an "interval appendix"—a favorite weasel word of the pathologist who's too spineless

#### SEVERE PAIN RELIEVED

# Without the Needle

PAPINE, orally administered, effectively relieves the most excrutiating pain. Contains morphine hydrochloride 1 gr. (60 mg.) and chloral hydrate 3 1/3 gr. (200 mg.) per fld. oz. in a palatable vehicle.

Average adult dose, 1 teaspoonful. Narcotic blank required. Supplied in 12 fld. oz. bottles for prescription and dispensing.

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### For the clinical accuracy your heart Every

For the clinical accuracy your heart practice demands . . and a degree of portability never before approached in the field of 'cardiography . . . this new Sanborn instrument offers a truly remarkable answer.

In the VISETTE you will find outstanding Sanborn quality and performance, achieved through the latest electronic techniques and the most modern principles of instrumentation. Tiny transistors largely replace bulky vacuum tubes ... entire circuits are contained in plug-in printed wiring panels no larger than a playing card . . . 'cardiograms are clearly traced on chart paper in a new, convenient width. Innovations such as these have also made possible economies in production, reflected in the comparably lower price of the new 300 VISETTE.

SANBORN

Every design feature, every component in this modern instrument, serves a single purpose: clinically accurate 'cardiograms with the greatest possible convenience. The "Sanborn man" in or near your city can provide complete details, and a demonstration in your office if you wish. And of course you may try a VISETTE (as you can other Sanborn instruments) – before buying, without cost or obligation.

To those who already own the famous Model 51 Viso-Cardiette, the new VISETTE can be an invaluable "companion" ECG - especially suited to use outside the office, or in hospital wards. Or, for those who prefer a larger instrument, using conventional 6 cm. width recording paper, the "51" is still available at \$785 delivered.

COMPANY



MO.

#### UNNECESSARY OPERATIONS

to report a normal appendix when he sees one.

That mother now regards my honest young friend as an incompetent. And she firmly believes the Great Surgeon saved her darling's life.

Did he cure her of her intermenstrual pain? Possibly—even probably—he did. Get a clear idea of the patient's situation and you'll see why:

The girl is a junior in high school, with all the goings-on kids that age can get into. Her life is full of too much activity, too much tension, not enough rest. Add to this the first awakenings



"Normally I practice only pediatrics, Miss White. But in your case . . ."

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clear



STERANE may not help him flush a covey, improve his aim or even help him bag a sitting duck...but STERANE can help steady your rheumatoid patient's hand and improve his position in almost any activity or profession by reducing joint pain, swelling and immobility. Provides prednisolone, the most active systemic corticoid, as white, scored 5 mg. tablets (bottles of 20 and 100) and pink, scored 1 mg. tablets (bottles of 100).



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#### UNNECESSARY OPERATIONS

of sexual interest in the young adult male, and her mind is "sicklied o'er" with a considerable sense of guilt.

That's the ideal situation for an unnecessary operation to effect a cure—temporarily.

#### How It 'Cures'

First, she gets caught up on some much needed rest. She spends six or seven days in the hospital. There's no running around nights. There are no outside activities. Given sedatives to sleep on, she relaxes completely for the first time in months.

Second, she has had a major operation. She realizes she must take care of herself, at least for a while. She rests more after she starts back to school. She cuts out some of the excess activity. She's even a little careful to eat more regularly and more sensibly. As a result, she stays relaxed for a long time. Tension builds up only slowly.

Third, her ego—her inner sense of importance—has been greatly strengthened. She has held the center of the stage for many days. This has given her an added fund of emotional strength to help her endure a degree of discomfort she'd have found incapacitating before the operation.

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. . . orally administered Xylocaine Viscous provides prompt and prolonged surface anesthesia in the upper digestive tract. Its cherry-flavored, water-soluble vehicle spreads evenly and adheres intimately to the membranes. Nonirritating and nonsensitizing ... just swish and swallow.

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Reciprocally acting nonsteroid antirheumatics...more effective than salicylate alone.

In each enteric-coated tablet: Sodium salicylate U.S.P. . . . 0.3 Gm. (5 gr.) Sodium para-aminobenzoate . 0.3 Gm. (5 gr.)

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Pabalate, with sodium salts replaced by potassium salts.

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Steroid

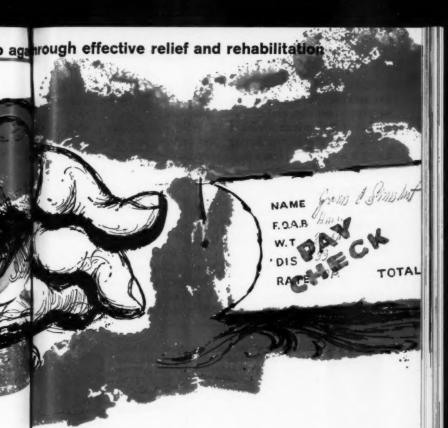
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50.0 mg

#### UNNECESSARY OPERATIONS

Fourth, but far from least, she has suffered. Through suffering we expiate our sins, real or fancied. So if she has been burdened with a sense of guilt over having found it delightful to kiss a boy, she's now free from sin.

#### Why It's Temporary

Why is the cure only temporary? The answer is obvious. Slowly, she gets back into the whirl. Her tension mounts. A year or two later, she starts having pains in her side all over again.

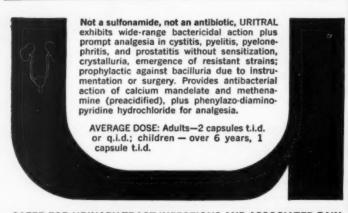
What should be done about those pains? The causes of ten-

sion should be removed, of course—but not by means of an operation.

What will be done? Well, I can make a guess at her medical history during the next twenty-five or thirty years. The Great Surgeon cured her once. So she goes to him again. This time he believes it's an ovary. Or perhaps adhesions. He'd better have a look.

And so, eighteen to thirty-six months after the first operation, she's operated on again.

You know the rest of the story. She probably marries in another



SAFER FOR URINARY TRACT INFECTIONS AND ASSOCIATED PAIN

# URITRAL



#### **Acute inflammation**

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Note spread of suppuration throughout the tissues and a marked swelling from surrounding edema.



Note regression of edema, swelling and acute inflammation after starting Chymar therapy.

Chymar

the newest and SAFEST anti-inflammatory agent

# Chymar

#### What it is ...

Chymar is a suspension of the proteolytic enzyme chymotrypsin in oil, for intramuscular use.

#### What it does ...

Chymar reduces and prevents inflammation irrespective of cause; reduces and prevents edema of inflammatory and traumatic origin; reduces pain; hastens absorption of blood and lymph effusions; restores circulation; promotes healing.

#### Why CHYMAR is so safe ...

It causes no undesirable local or systemic reactions; has no known contraindications—no known incompatibilities; has no influence on blood clotting mechanism; does not spread infection, but augments the action of concurrently used antibiotics.

### Indications... Prophylactic and Therapeutic

Chymar is indicated in all conditions in which inflammation and edema retard healing. 1) Accidental injuries: Black eyes, bruises, hematomas, wounds, burns, sprains, fractures, bursitis. 2) Surgery: Biopsies, cellulitis, hernia repair, hemorrhoidectomies, G. I. surgery (to prevent edema and hematomas at site of anastomosis), mammectomies, orchitis, epididymitis, prostatitis, phlebitis, thrombophlebitis, skin ulcers (as an adjunct to Tryptar Antibiotic Ointment). 3) Obstetrics: Breast engorgement (postpartum), cephalohematoma, episiotomies. 4) Eye Diseases: Inflammation, trauma, edema, hematomas (blood in anterior chamber), pre- and postsurgically.

Supply: 5 cc. vials. Each 1 cc. contains 5000 units of proteolytic activity.



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MEDICAL ECONOMICS · JUNE 1957 207

year or two. During the next six or eight years, while she's acquiring a family, she's too busy to worry about herself. But when the babies start growing up and she no longer feels all-important to them and her husband, the old pains come back.

#### **History Repeated**

So it's back to the same old operator. During the next ten to fifteen years, she's operated on for her gall bladder and for adhesions; and of course she has a hysterectomy. Between the ages of 15 and 45, she has a min-

imum of five major operations. And not one of them is really necessary.

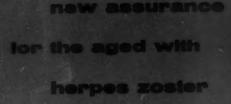
The Great Surgeon never fails to give her temporary relief, however. So her enthusiasm for him never flags. She recommends him to all her friends. And they recommend him to theirs.

As a result, his practice flourishes like the green bay tree.

Why isn't he stopped? Why is he permitted to continue, when many of his colleagues on the staff of the same hospital know what's going on?

Well, perhaps only a small





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and greater freedom from
postherpetic neuralgia.

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number at any one time are *really* on to him. The members of the tissue committee are the doctors most acutely aware of the number of normal tissues removed. The members of the records committee are also in the know. But these two groups together probably constitute less than one-tenth of the total staff membership.

They may rightly be worked up over the situation. But the other doctors are all so busy... Why worry them about matters that can only mean unpleasantness if they're stirred up? Better let sleeping dogs lie...

#### Why They're Silent

There's good reason, of course, for the attitude of the tissue and records committee members. This type of surgeon, remember, is inherently unscrupulous. He wouldn't be doing what he does if he weren't. So if anyone dares question his actions and motives, he'll bar no holds in fighting back.

He'll call the fault finders "jealous." He'll accuse them of seeking to discredit him merely because they're envious of his big practice. If they mention a few of the normal tissues removed, he'll shrug it off with the incontrovertible remark that "We all make mistakes." Or he may make this comeback: "I don't care what the pathologist said. It was an inflamed appendix. As the clinician on the case, my word goes ahead of his."

#### **Patients Support Him**

And don't forget this: For almost any given instance, he can get a layman to testify that after three or four other doctors failed to cure him, the Great Surgeon's operation on him did the trick. You can be sure there are plenty of recently "cured" patients ready to fight for him, if need be.

How can such men be stopped from doing unnecessary operations? Only by courageous action on the part of records and tissue committees. These committees must be willing to stand up and insist that records be kept adequately and that normal tissues removed be held to a minimum.

Theirs may very well be an unpleasant duty. But if we're to make any pretense of living up to our professional ideal of honest, competent medical care, we physicians *must* accept the job of policing ourselves. END

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prevented... if this young woman had consulted a physician when her acne first appeared years ago—instead of vacillating between self-treatment and neglect.

...<u>if</u> her parents had relied on proper medical treatment—instead of well-intentioned platitudes: "everybody gets pimples"..."leave them alone and they'll go away"..."no need to bother the doctor."

When a teen-ager with acne comes to you for any reason—treat the acne, too!

## ACNOMEL\*

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the most widely prescribed acne preparation Smith, Kline & French Laboratories, Philadelphia

\*T.M. Reg. U.S. Pat. Off.



Planning Your Family's

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## Ways to Leave Me

When and how they inherit your estate is just as important as the amount they get, says this lawyer

By René A. Wormser, LL.B.

Faulty estate planning is one of the easiest ways to blight the lives of your children. If you doubt it, take note of these real-life examples:

¶ Dr. A is 81 years old and wealthy. He has a daughter living in quite modest circumstances; yet he still holds on grimly to every nickel of his fortune. His daughter's views on money are understandably becoming warped. When she finally does come into the estate, she may not be able to bring a sensible attitude to bear on the privileges and responsibilities that go with it.

¶ Dr. B died in 1945, leaving everything outright to his son, then aged 21. Within three years, most of the money was gone—dissipated in a starry-eyed scheme for prospecting oil in Central America. In the twelve years

THE AUTHOR combines a busy law practice with teaching, writing, and lecturing. He's chairman of the advanced estate-planning panels at the New York Practising Law Institute. He's also the author of a number of books. One of them, "Personal Estate Planning in a Changing World," is considered the standard layman's guide to the subject.

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## ve Money to Your Heirs

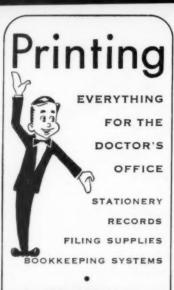
since then, the son has had some small success in the insurance business. But he and his family may never enjoy the life they could have had if his father had taken steps to protect him from a youthful error of judgment.

¶ Dr. C chose to be super-careful, leaving his estate in trust for his son for life. The son is now 36 and has never worked. Since his income is a comfortable one, he sees no point in taking a job. Several years ago, he had an attractive opportunity to go into business; but he couldn't raise the capital. The trust contains no provision for paying out principal.

Even with the best of intentions, sound planning for your children is no snap. What you can give them in education, training, and character-building is obviously as important as the amount of money you leave them.

In my experience, few people develop the judgment to handle substantial sums of money until they progress several years beyond legal maturity. I favor 28 or so as the average good-sense age. If a son hasn't a reasonably level business head by the time he reaches 28, he may never have one.

The installment method of giving has much to commend it. Through a trust created by will, you can, for ex-



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#### MONEY TO YOUR HEIRS

ample, specify that your son receive one part of his expectancy at 26, another part at 28, the rest at 30. Or you can spread the payments still more. If the boy loses some of his first money, he may learn lessons that will help him do better with what comes later.

#### Wife Comes First

All this assumes that your wife is fully provided for. She comes first, of course. But if you're leaving a sizable estate, there's no reason why your children shouldn't receive something during her lifetime.

You can stipulate that payments be made to a son or daughter at a certain age, or you can authorize your trustee to make payments for a specified purpose or even at his own discretion. Whenever possible, children should be given access to principal for such reasons as improving themselves in business, setting themselves up in a profession, or otherwise enhancing their opportunities and earning power.

#### Don't Wait Too Long

With estate taxes as they are, you'd also do well to consider giving your children something during your own lifetime. Such gifts can be important to their

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INCREMIN offers 1-Lysine for improved protein utilization, and essential vitamins for their stimulating effect on appetite.

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#### WAYS TO LEAVE MONEY TO YOUR HEIRS

education in money management.

A man owes some instruction in money management to both his wife and children. If you have a daughter, don't assume that her investment affairs will be handled properly by her husband; he may be the impractical sort. Besides, most wealth sooner or later falls into the hands of women—most of whom are pa-

thetically ill-prepared for the responsibility.

In planning for a son, don't forget about his wife. An eminent judge once referred to the daughter-in-law as "the forgotten woman" in estate and trust matters. The remark was prompted by the testamentary trusts he'd read—many of them providing that if the son died before coming into the principal,



"You look awful. Didn't you get my get-well card?"

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"...17 of...20 patients with post-traumatic muscle spasm of the low back had excellent or good responses."<sup>2</sup>

"In acute and chronic recurrent low back syndrome, seven of eight patients showed visible objective improvement."

#### Bibliography

(1) Johnson, H. J., Jr.: To be published. (2) Wallace, S. L.: To be published. (3) Settel, E.: Am. Pract. & Digest Treat. 8:443, 1957.

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the son's widow was to be bypassed and the money earmarked for her children.

When this happens, a court guardianship is set up; the fund is then administered under it. Investments in such cases are ultraconservative. The income is correspondingly low. The mother must go to court for periodic hand-outs to keep the family going. And when the children come of age and get the principal, she's thrown on her own resources.

It seems to me that a man truly interested in his grandchildren should provide fair treatment for

the woman who brings them up. At least he can give his son power of appointment under the trust, letting the son decide what interests and management rights his wife should have.

#### Name a Trustee

A court guardianship is seldom a desirable thing. If any of your immediate heirs is under 21, you'd be wise to add an administrative clause to your will, obviating the need for the court's stepping in.

Through such a clause, you can appoint a trustee to admin-

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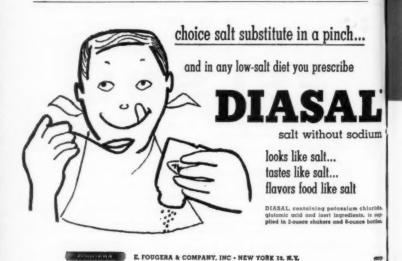
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#### WAYS TO LEAVE MONEY TO YOUR HEIRS

ister the child's property as a trust. You can give the trustee all the investment latitude possible under the ordinary trust form. You can authorize him to accumulate whatever part of the income he sees fit and pay the rest (or some of the principal, for that matter) to the child or to anyone else for the child's benefit (for example, to a boarding school).

Whether or not you appoint a trustee, name a guardian for any under-age children who are direct beneficiaries under your will. If your wife survives you, she cannot be deprived of guardianship, except on very serious grounds. If you're a widower, the next of kin is ordinarily entitled to this role. But the court will always give your appointment the greatest possible weight. For instance, if it's a choice between one or the other of the child's grandmothers, your selection will almost certainly tip the balance.

You can, if you wish, divide the guardianship function. That is, you can appoint one person to have physical custody of the child and another to manage his funds. This is an unusual step, but one worth keeping in mind.





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## Tips on Talking With the New Patient

The first visit is the best time to let him see that you consider him a person, not just a case

By John E. Eichenlaub, M.D.

Two out of five Americans charge that doctors have no personal interest in their patients. If this charge isn't true, where does the misunderstanding arise?

Maybe on the first visit. New patients enter your consulting room with their emotional antennae all the way out, probing for evidence of how you feel toward them. They're palpably hoping that you'll value them as people, not just as "cases," and anxiously watching for your response.

How can you *show* that you value them as people? With simple courtesy, for one thing. You can easily meet

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each new patient at the door. It doesn't take much time to introduce yourself, even though you both know who the other is. It's the gracious gesture, not the information, that counts.

After the greeting, how to show personal interest before getting down to business? Here's one good technique: Bring out the patient's distinctions, or what he regards as his distinctions. Talk about something that puts the patient in a good light.

Here's the way one such exchange went:

The doctor glanced at his new patient's record.

"So you're a railroad brakeman?" he said. "I'll bet you've seen a lot of the country in that job!"

"Yes, sir. I've got around, all right."

"How long have you been at it?"

"Sixteen years. With the road, that is. Not all as brakeman."

"How many miles do you estimate you've traveled?"

The patient swelled with pride. "Near a million miles,
I guess," he said.

"Well!" the doctor blinked admiringly. Then he pulled the chart closer.

"Now what can I do for you?" he asked . . .

#### **Patient Sets Pace**

How can you convince the patient that you care about him as you draw out his story? A colleague of mine used two techniques in a recent interview: He let the patient

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set the pace, and he used the patient's cues in selecting key words.

"Now then," he said. "What's your problem?"

"It's my back," the patient said. "It's been giving me fits for the past two weeks."

"When did it first give you fits?"

"Three-four years ago." The patient's brow furrowed in thought. The doctor did not interrupt. The man finally went on: "Right after I heisted that barrel. It was muddy that day, and my foot slipped a bit. I didn't fall, but it give me a catch in my back."

"Was this catch in your back the same as when it gives you fits?"

#### The Patient Elaborates

"No. That wasn't till the next day. The catch in my back was just like something snapped, and then it passed over. But the next day I was real sore."

"And how many times since?"
"Six."

"Stand up and show me exactly where it hurts when it gives you fits."

This doctor lets his patients carry the conversational ball as

much as possible, entering only to keep things moving in the right general direction. You may not always have time for such an unstructured interview, and some patients may need to be led more actively toward the main points. But the point is this: Free-response questions, which require a full, subjective answer, put the patient in the center of the stage.

#### **How to Frame Questions**

In a clinic I know of, the classic history sheet was recast, item by item, into free-response questions. "Are your menstrual periods normal?" became "How about your menstrual periods?" "Have you gained or lost weight recently?" became "What's happened to your weight in the past year?" "Do you have to urinate more frequently than normal?" became "How many times a day do you have to urinate?"

Some doctors draw out the patient's story without actual questions. This seems to reach the complaint in an especially interested, respectful way. The actual techniques? Here are three that seem to work:

1. Imperatives. One doctor echoes the patient's wording of

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#### TALKING WITH THE NEW PATIENT

his complaint with: "Now tell me about your 'stomach trouble.' " Another doctor's pet expression is: "Bring me up to date on this condition."

2. Expectant statements. Perhaps the commonest expectant statement is: "Now we're going to talk about your main trouble." You pause, and the patient usually starts to talk before you need to ask questions.

3. Provocative statements. There are some remarks that leave an inescapable void into which patients must march. For instance: "This 'peculiar feeling'

you have—now I'm not quite clear about that." The patient has to make further explanation, but certainly doesn't feel that he's being led by the nose.

#### Word of Caution

So much for positive ways of showing interest and respect while you're getting down to business with a patient. There's one more point, though, which a colleague of mine recently made:

"You've got to keep patients from feeling like fools," he said. "They're in a strange situation,

when advancing age calls
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The anabolic and tonic effects of the hormones in Plestran appear to be enhanced by combination so that small dosages are very effective. Combination also overcomes some of the disadvantages of therapy with a single sex hormone, such as virilization, feminization or withdrawal bleeding.<sup>5</sup>

**Dosage:** Usually one tablet daily; occasional patients may require two tablets daily, depending on clinical response.

Supplied in bottles of 100 and 500.

References: 1. McGavack, T. H.: Geriatrics 5:151 (May-June) 1950. 2. Masters, W. H.: Obst. & Gynec. 8:61 (July) 1956. 3. Kimble, S. T., and Stieglitz, E. J.: Geriatrics 7:20 (Jan.-Feb.) 1952. 4. Kountz, W. B., and Chieffi, M.: Geriatrics 2:344 (Nov.-Dec.) 1947. 5. Birnberg, C. H., and Kurzrok, R.: J. Am. Geriatrics Soc. 3:656 (Sept.) 1955.

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#### TALKING WITH THE NEW PATIENT

talking about things they've no good words to convey and approaching issues that often belittle their strength, modesty, or good sense. I try to keep patients out of such jams, at least until we're well acquainted."

"How?" I asked.

#### Watch for Signs

"By keeping my eye out for weather signs. Watch your patient's mouth, his shoulders, and his hands. You'll know when he sees trouble ahead. If you can't solve his problem by a leading question or the like, switch the topic for a while. Make a mental note to fill in that gap later, after you're on solid ground with him."

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"You say 'make a mental note.' Don't you write these things down?"

"No. You've got to put the patient's feelings at the top of your list, ahead of the gathering of scientific facts. That's true of the whole interview, but especially right at the start." [MORE]



"All right, then, have it your way!"

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# METICORTEN



Perhaps compassionate respect is the term for what patients call personal interest. But whatever term you use, personal interest is important because it attracts—and holds—new patients. And it helps you to treat them effectively.

## Surgeon at the Sacrificial Altar

It was just a thyroidectomy—but to those awestruck natives, it was a battle of supernatural powers

By Melvin A. Casberg, M.D.

In January, 1941, my wife, our two children, and I sailed for India, where I was to run a mission hospital. It lay far off the beaten path in the jungles of Berar Province. The Umri Hospital had been built for the Free Methodist Mission by my father, an architectural missionary, about 1915. Unhappily, the Mission could then get neither funds nor a physician to run the institution, so it had never been used. Modern medical science had yet to reach this province, and endemic and epidemic diseases were unchecked.

When I arrived at the Umri Mission Station, where I'd spent much of my childhood, I was still in a quandary as to how modern medicine might best be introduced into the area. For here man's physical and mental conditions were not held to have mere earthly causes. They were all caused by the mysterious operations of whatever power

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**complete relief...** more frequently obtained because of the complementary actions of the two antihistamines and the sympathomimetic, 'Clopane Hydrochloride' (Cyclopentamine Hydrochloride, Lilly).

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had the upper hand in the constant battle for man between the legions of good and evil.

The whole future of the mission project would depend on the reaction of the superstitious natives to their first contacts with the hospital. Years of planning and building could come to naught should they fear, resent, or distrust our purpose.

#### **They Trusted Us**

But soon many patients were making their way to the hospital. Most were in dire need of medical care. Others were mainly bent on satisfying their curiosity. Any local fear of our intentions soon seemed to have been dispelled.

Our next step was to find a suitable case with which to dem-

onstrate the benefits of surgery. Removing an appendix or even a good portion of the stomach would mean little to these natives, who lived in and about the jungles and could boast scars far greater than those required for even the most extensive surgery.

Then one day the ideal patient presented herself, seeking relief from a very large and deforming goiter. A custom in many Indian mission hospitals was to have a near relation or responsible friend of the patient's sit in a corner of the operating room to witness the surgical procedure. In an area of relative illiteracy, where signed operative permits would be little understood, this observer fulfilled such legal requirements.

#### Enthusiastic Witness

From the moment that it was explained to the nephew of the little old woman with the goiter that he would be privileged to witness the surgery, I had an ardent and enthusiastic supporter. In fact, the pre-operative delay of a few days necessary to prepare the patient was a great irritation to this young man who'd become so important a part of the surgical team.



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Immediately following the surgery, the nephew hurried home and gathered all the villagen about him to hear the story. The men squatted on the ground in close semicircles immediately before the narrator, while the women, children, dogs, and cattle made up the rear echelon. One of the mission-school teachers happened to be in the audience. And the next morning he gave me a detailed account of the dramatic presentation.

The young nephew had missed little, and his descriptions were accurate. But his attempted interpretations of the acts, quite in keeping with the limits of his knowledge and the locally accepted philosophy of health, were the wonderfully interesting part of it:

#### The Nephew's Story

"I was taken to the temple of healing where, after being gowned in holy white robes and my face and head covered, I was led to the Holy of Holies and seated in a corner.

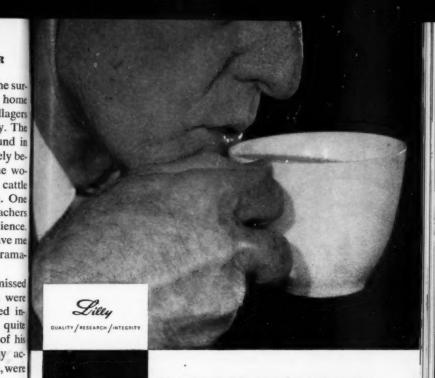
"The presence of the gods in the sanctuary was so overpowering that not only I but everyone entering hid his face and covered his head.

"The doctor sahib came into the Holy of Holies and washed

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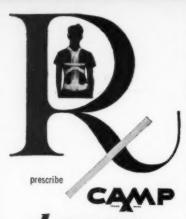
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### SACRIFICIAL ALTAR

his unclean hands for many minutes in a ritual of purification. Between washings he anointed his hands with oil."

(Anointing with oil being a time-honored religious rite, it was only natural that the observer mistook for oil the liquid soap squirted on my hands by a dispensing machine.)

### Still Unclean

"Then, after all these religious procedures, the doctor sahib was still not purified and had to cover his white robe with yet another robe, and his hands with gloves, lest he defile the sanctuary. Then my aunt was brought into the Holy of Holies and placed upon the sacrificial altar."

(To me, a surgeon, such a definition of the operating table was startling, to say the least!)

### **A Priestess Enters**

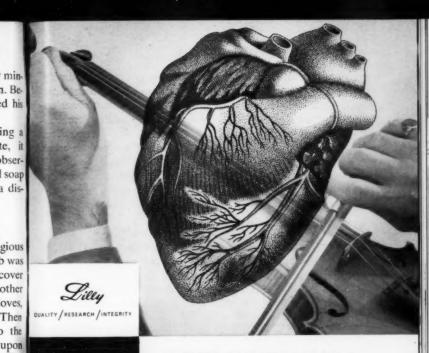
"There then came into the room a priestess who sat at the head of the sacrificial altar and invoked the blessing of the gods. After this she breathed upon my aunt and caused her to fall into a deep slumber."

(In the Book of Genesis we read of the Lord breathing life into Adam. This concept occurs frequently in the Orient, especially in reference to the trans-

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### SURGEON AT THE SACRIFICIAL ALTAR

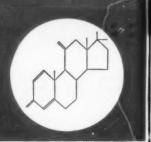
ference of supernatural powers. Hence, the nephew saw the anesthetist with her apparatus, bowing over the patient's head and talking in low tones, as a priestess chanting her incantations and breathing into the nostrils of the recumbent aunt. What a delightful name for an anesthetist—a priestess of sleep!)

## 'He Slit Her Throat'

"When my aunt was deep in slumber, the doctor sahib slit her throat from ear to ear as a sacrificial gesture, trying to appease the gods with her blood. He and his assistant priests wrestled with the evil spirits for a long time. The strain of the battle was so great that the sahib's forehead became wet with perspiration and a priestess mopped his brow many times. Finally the evil spirits were overcome and so they rushed from the neck of my aunt, leaving her no longer possessed."

Thus ended the surgical drama—a thyroidectomy in modern medical parlance, but a battle between the gods and the evil spirits when seen through the eyes of an Indian villager. END

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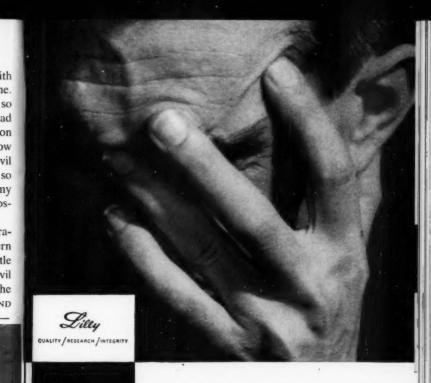
1: Bollet, A.J., Black, R., and Bunim, J.J.: J.A.M.A. 186:459 (June 11) 1955

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# How to Get People To Accept Your Advice

After studying patients' reactions to what doctors told them, this man has come up with five good tips

By David Rutherford

In my interviews with hospitalized patients, I find that they tend to talk with surprising frankness about the various doctors they've been to. And I find a lot of lingering resentment that I attribute to just one thing:

Some doctors gave them the right advice in the wrong way. As a result, such patients didn't take the advice—and *did* take a lasting dislike to the doctors.

Advice-giving is a ticklish business at best. Unfortunately, it is also one in which a doctor may give unintentional offense more easily than almost anyone else.

That's because medical advice often deals with things the patient isn't happy to hear about. And much of it touches on intimate details loaded with the seeds of acute embarrassment.

But there are ways of reducing the risk. Some doctors have developed advice-giving techniques that are nearly

THE AUTHON, who writes here under a pen name, is a clinical psychologist on the staff of a large hospital in the East.



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### HOW TO GET YOUR ADVICE ACCEPTED

foolproof. And a good many patients, after rejecting what Dr. X told them, have later accepted exactly the same advice from Dr. Y, who served it up in a different manner.

No matter what counsel you have to give, or to whom you're about to give it, signs are you'll get better results if you keep in mind a few simple rules:

 Lead your patient to the psychological point at which he'll be most receptive to the advice.
 And remember: He won't be receptive unless he has some idea of the reasons for it.

But don't such explanations take too much time? Not necessarily, say doctors who make a point of them. Most of them can be made during routine procedures when there's usually some conversation anyway.

In hard-to-advise cases, it's wise to heed the well-known axiom: The more dissatisfied a patient is with his present condition, the more readily he'll accept advice for correcting it. [MORE]



"Darling, we've got to quit meeting this way. I'm afraid I'll go really batty."

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### HOW TO GET YOUR ADVICE ACCEPTED

Take the case of a young insurance salesman whose leg, injured in an automobile accident, had mended badly. No amount of argument could make him agree to the surgery recommended.

"So I stopped arguing," said the doctor. "Instead, one day, I got him talking about himself. In no time he was telling how his bad leg interfered with calls on prospects, reduced his income, and left him feeling worn out."

The doctor grinned. "Before he knew it, that fellow had shown himself how the bad leg was hampering his career and spoiling his enjoyment of life. In ten minutes he'd sold himself the recommendation I couldn't interest him in. He had the operation. And now his leg is as good as new."

### Give Him the Facts

Even when the patient's present condition isn't too bad, you may want to point out how neglect of your advice might make it worse. In any case, a patient has a right to know what the total results of his ailment may be.

This warning against possible future trouble works well for a pediatrician I know. She used to



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find that only 10 per cent of the parents to whom she recommended a child guidance clinic actually took their children there.

# **Now They Cooperate**

"But things changed when I began to show the parents that their children's problems might grow worse," she says: "—that the youngsters might grow up to be poor social personalities, poor career risks, poor citizens. Now about 75 per cent of them act on my referrals."

2. Let your patient feel he has a hand in making the decisions

that will affect him. He isn't, after all, a horse to be hitched to a wagon and driven off in whatever direction his doctor chooses.

A gynecologist I know can't understand why he always seems to have an uncommonly unco-operative lot of patients. His colleagues wonder if it isn't because he addresses his advice to them in the tone and manner of a drill sergeant barking at an incompetent rookie.

The dictatorial approach, far from keeping the patient in line, may have the opposite effect. Feeling that his ego has been

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# AVEENO $^{\odot}$ Colloidal Oatmeal is available in 18 oz. and 4 lb. boxes a diagnosis cannot readily be made.

### GET ADVICE ACCEPTED

slighted, he's apt to disregard the advice as a means of reasserting his independence.

On the other hand, when a patient takes part in a decision, he feels responsible for carrying it out.

# Talk Their Language

One way to give the patient a sense of being in on things is to pitch the advice from his corner. As a young gastroenterologist put it to me: "I started getting real cooperation from my patients the day I stopped saying, 'I want you to take this medicine, Mrs. Jones.' By changing it to, 'You'll find this medicine helpful,' I was talking Mrs. Jones' language and bringing her into the act."

Best of all is to have the patient suggest the advice. A wellknown cardiologist has been using this method with gratifying success. Here's his formula:

"I sketch for the patient all the facts I think he needs to know. They're slanted, of course, so he can see plainly what anyone in his condition ought to do. Then I say, 'If you were the doctor, and I the patient, what would you advise me to do?' Almost always he suggests pretty much what I had in mind for him. Then all I have to do is fill in the details."

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# A Universal Pediatric Problem ...Iron Deficiency Anemia

"Iron deficiency is the most common nutritional deficiency encountered in children," appearing most frequently between six and twenty-four months of age.¹

In fact, after the fourth month a well defined iron deficiency state is characteristic of normal infancy.²

The first approach to iron deficiency anemia is prevention.<sup>3</sup>
"Iron after the third or fourth month...is essential
...well utilized and will prevent the development
of hypochromic anemia."<sup>4</sup>

1. Smith, N. J., and Rosello, S.: J. Clin. Nutr. 1:275 (May-June) 1953.

2. Sturgeon, P.: Pediatrics 13:107 (Feb.) 1954,

3. McLean, E. 8.: Pediatrics 7:136 (Jan.) 1951.

4. Jackson, R. L.: J.A.M.A. 160:976 (Mar. 17) 1956.

5. Tuttle, A. H., and Etteldorf, J. N.: J. Pediat. 41:170 (Aug.) 1952.

6. Dieckmann, W. J., and Priddle, H. D.: Am. J. Obstet. & Gynec. 57:541 (Mar.) 1949.

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Also: tablets in bottles of 100.

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In short, the more you can make the patient feel he's helping to shape the advice he's getting, the better the result.

### Don't Embarrass Them

3. Spare your patient embarrassment by taking a factual, dignified approach to intimate subjects. Not many people, even in these free-spoken days, can discuss details of their more intimate bodily functions without self-consciousness.

How to approach these matters is one of the doctor's most troublesome problems, especially since the person across the desk may react in any of several ways. Only one thing is sure: That reaction will depend almost entirely on the doctor's attitude. If the M.D. squirms or cracks his knuckles, the patient's discomfort is likely to match his own.

"First time I advised a patient about a very personal matter," one doctor recalled, "I tried a casual, off-the-cuff, somewhat earthy style. It didn't work. It created a poolroom atmosphere that made us both uncomfortable.

"Since then I've learned to dis-

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(Deserpidine, Abbott)



introduces a new degree of safety in major tranquilizing antihypertensive therapy



Most significant: In extensive trials, Harmonyl has produced less mental and physical depression. And there are very few reports of the lethargy seen with many other rauwolfia preparations.

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More than two years of clinical evaluation have proven Harmonyl a notably safe and effective agent in cases ranging from mild anxiety to major mental illnesses and in hypertension. Harmonyl exhibited significantly fewer and milder side effects in comparative studies with reserpine—while demonstrating effectiveness comparable to the most potent forms of rauwolfia.

# Safety-plus marked clinical effectiveness

Harmonyl proved particularly effective, for example, in tranquilizing a group of 40 chronically ill, agitated senile patients.<sup>1</sup>

Of particular interest is the observation that patients became more lucid and alert on Harmonyl therapy. And there was a complete absence of side effects with Harmonyl—although a similar group on reserpine developed auch side effects as anorexia, headache, bizarre dreams, shakes, nausea and vomiting.

Following another eight-month study of chronic, hospitalized mental patients, Ferguson<sup>2</sup> stated:

- Harmonyl benefited at least 15% more overactive patients and proved more potent in controlling aggression—requiring only onehalf to two-thirds the dosage of reserpine.
- Patients experiencing side reactions on reserpine often were completely relieved when changed to Harmonyl.

Ferguson concluded: "The most notable impressions were the absence of

side effects and relatively rapid onset of action with Harmonyl."

Comparative studies have shown Harmonyl and reserpine about equal in hypotensive effect. The tranquilizing action of the two drugs also appeared similar—except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were seen with Harmonyl.

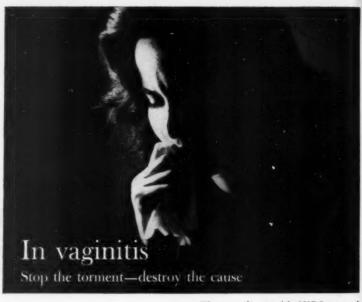
Dosages: In mild anxiety, as little as 0.1 mg. a day may be effective. In institutionalized psychiatric cases, not less than 2 to 3 mg. a day is likely to be beneficial.

In mild essential hypertension, treatment may be started with one 0.25 mg. Harmonyl tablet three or four times a day. After about ten days (or sooner, depending on response), dosage may be reduced. A maintenance dose of 0.25 mg. daily is often sufficient.

Precautions: As with other forms of rauwolfia, Harmonyl should be used cautiously in peptic ulcer, epilepsy and in patients about to undergo surgery or electroshock treatment. Despite the infrequency of reports involving depression, patients with a history of depressive episodes should be watched carefully.

Professional literature with complete information is available upon request. Harmonyl is supplied in 0.1-mg., 0.25-mg., and 1-mg. tablets.

References: 1. Communication to Abbott Laboratories, 1956. 2. Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report. Journal Lancet, 76:389, December, 1956. \*Trademark



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Administration: An applicatorful twice daily —on arising and at bedtime.

Supplied: 4 oz. tubes with or without applicator.

(1) Cortese, J. T.: Clin. Med. 2:45, 1955. (2) Hensel, H. A.: Postgrad. Med. 8:293, 1950. (3) Horoschak, A. and Horoschak, S.: J. M. Soc. New Jersey 43:92, 1946.

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### GET ADVICE ACCEPTED

cuss intimate problems warmly but with detachment. I try to approximate the attitude I'd take, say, with a troublesome ingrown toenail."

Patients and doctors generally seem to agree that the "indelicate" problem is best treated factually. Let it be brought up as a perfectly natural subject for discussion and one that calls for no apology.

# **Sugar-Coated Pill**

4. Try to make your disagreeable advice palatable. Here, as in many another case, the sugarcoated pill has it all over the bitter one.

The patients of an internist I know are the envy of his colleagues. They never rebel when he gives them hard-to-take advice. They accept it willingly and thrive on it.

"It's all because of a little trick of giving the patient a chance to feel noble and unselfish," this doctor confessed to me. "People actually feel good about making a painful sacrifice if they think it will help someone they care about—a wife, a mother, or the children. That man who just left my office has agreed to a strict diet for the sake of the Little Woman. He'd never have done it just for himself." [MORE ▶

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### HOW TO GET YOUR ADVICE ACCEPTED

The head of a well-known clinic adds this tip: A patient can often be persuaded to stick to an utterly repugnant regimen by adroit references to his courage, his integrity and, in particular, his will power.

He can indeed. As a hospitalized patient confided recently: "The doctor said he wouldn't think of prescribing this diet for the ordinary person, but he thought I might have the guts to stick to it. And, you know, it isn't

so bad, now that I've got used to it."

People will put up with a lot of discomfort if it enables them to think of themselves as better, stronger, finer persons. This is a good thing to keep in mind whenever you're about to dispense your most distasteful advice.

5. Be prepared for the occasional patient who, having considered your advice in its most appealing aspects, still won't have



"... And stop wheeling these twins through the alcoholic ward!"

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Life without Frenzy

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He used to fuss and fume when traffic slowed him down. Now he relaxes—his pace of living has been "calmed down"—since his doctor prescribed

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# Steroid-Nutritional Therapy Is Constructive Approach for the First Signs of Aging

# Emphasis on Early Treatment Before "Damage" Is Done

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Some of the most common symptoms of declining gonadal function and nutritional insufficiency are vague pains in the bones and joints, easy fatigability, decreased muscular tone, loss of appetite, chronic mental fatigue and general malaise. In older patients, these complaints are frequently indicative of degenerative processes when they cannot be attributed to a specific cause.

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"Mediatric" supplies estrogen and androgen in small quantities to help maintain important metabolic functions, dietary supplements to ensure adequate nutrition, and a mild antidepressant to elevate the mood. Recommended dosages: Male - 1 tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required. Female - 1 tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required, taken in 21 day courses with a rest period of one week between courses.

Bibliography on request.

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Each 15 cc. (3 teaspoonfuls) contains:
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Contains 15% alcohol

Capsules-No. 252-bottles of 30, 100, and 1,000.

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Media apsules MEDIATRIC" will promote better health and vigor when he patient complains of . . . easy fatigability . . . vague pains in he bones and joints

These symptoms may be the first signs of degenerative changes in atients over 40. "Mediatric" supplies small doses of estrogen and androgen, important dietary supplements and a mild antidepressant of forestall or even correct the "damage" of premature aging.

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any part of it. You won't meet him often; but when you do, an extra set of emergency precepts will come in handy.

An astute general practitioner with whom I've discussed this problem offers this formula:

¶ Let the patient express his objections fully and freely. It's quite possible he'll talk himself around to your point of view.

Repeat his arguments after him. Let him know you understand why he feels as he does and that there's something to what he says. When he finds you arguing from his point of view, he may reverse himself and start arguing from yours.

¶ Make it clear that your patient has a perfect right to make up his own mind whether or not to take your advice. If he's protesting just because he feels a need to assert himself, he'll probably give in once you've recognized his independence.

¶ If everything else fails, leave the way open for the patient to come back another time. If you haven't insisted that he take your advice, he may think it over in private and come to see it your way.

[MORE ▶

# Price No Object

A colleague of mine was awakened by a telephone call at 5 A.M. A woman's voice said: "Doctor, will you please come to see my husband? He's been coughing all night and is running a fever and says his chest hurts."

The doctor explained that he could come immediately, but that if she could wait two more hours he would see her husband on the way to the hospital and thereby save her the added expense of a night call.

Without hesitation, the voice answered: "I think you had better come right now. We can't pay you anyway."

-WILLIAM J. BRADLEY III, M.D.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS pays \$25 to \$40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.

"I used to lose arguments with patients consistently, no matter how good my points," this doctor says. "Now, when a patient disagrees with me, I sit back and let him argue with himself. Result: I nearly always win."

A physician can't avoid giving

the advice that's demanded of him daily, come Johnny with his rash, Dad with his asthma, and Grandma with her rheumatism. But he can tune up and lubricate his advice-giving techniques—and in that way avoid a lot of needless friction.

# Medicine Chest For a Trip Abroad

By Henry A. Davidson, M.D.

When a doctor takes a trip, the others in his party expect him to produce appropriate medication every time someone has a pain, a diarrhea, or a cough. If he's traveling by automobile in this country, the answer's simple: He tosses his own medical bag into the car trunk. But if he's flying somewhere or going abroad, he probably won't give precious baggage space to his full medical bag.

Every summer, my wife and I take a trip with two other couples. I'm the only M.D. among the six. Though I practice in a highly specialized field, I'd lose face if I didn't come up with some kind of medical remedy in a crisis. We usually fly to our first destination, so baggage weight and luggage space are factors. I can't take a portable pharmacy.

Over the years, I've tried different methods of pack-

# In Angina Pectoris More ith his Comprehensive Action entoxylon

he patient with angina pectoris requires the comprehensive approach provided by the several actions of Pentoxylon. Each tablet combines the valuable tranquilizing, fear-relieving, bradycrotic, and nonsoporific sedative actions of Rauwiloid® (alseroxylon, 0.5 mg.), together with the long-lasting coronary vasodilating effect of pentaerythritol tetranitrate (PETN, 10 mg.).

- Reduces incidence and severity of attacks
- Increases exercise tolerance
- Reduces tachycardia
- Reduces anxiety, allays apprehension
- Reduces nitroglycerin need
- Lowers blood pressure only in hypertensives
- Produces demonstrable ECG improvement

Dosage: one to two tablets q.i.d., before meals and on retiring

P.S. to stop the acute attack faster Medihaler-NitroIM, the new self-propelled. measured-dose inhalation method delivers 1% octyl nitrite for instantaneous relief of acute anginal pain.



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### MEDICINE CHEST FOR A TRIP ABROAD

ing and various combinations of drugs. Here's the end product of considerable trial and error:

Liquids spill, and ointments can mess up your baggage. I do take a nasal spray and four ointments, however, because there's no other way of getting certain medications. The four ointments are a salve for burns (including sunburn) and ophthalmic, antipruritic, and antibiotic ointments

The ophthalmic ointment is in a tiny tube that I carry in my toilet kit. The other three ointments are in one-ounce tubes in 4½-inch cardboard containers. I put them in a plastic envelope that I once picked up as a part of an airplane "flight kit." They take up very little room and add very little weight. [MORE]



"Dear General Smaltz: Your suggestion about the addition of Reserpine to the water supply of certain foreign nations intrigues me . . ."

ments. it is in n my ointbes in iers. I elope part They d add

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stops poison ivy itchingeven before it starts

prevents Rhus dermatitis when applied prophylactically relieves existing dermatitis when applied 3 or 4 times a day

new 1

(1) Pyribenzamine, an established antipruritic, promptly stops itching preventing development or spread of lesions.

### HOW TO USE-

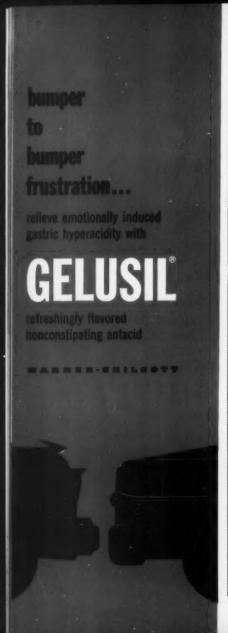
As a prophylactic measure: Apply Antivy generously to exposed areas anticipated or as soon as possible after contact.

As a therapeutic measure: Apply generously to the affected area and

### SUPPLIED

Antivy Lotion, containing 2% Pyribenzamine 8 hydrochloride (frigetennamine hydrochloride CIBA) and 4% zirconium oxide (as hydrous

ine



### MEDICINES FOR A TRIP

How about tablets and capsules? I carry an even dozen types:

- 1. A sleep-producing tablet or capsule.
- 2. A tablet laxative of the dihydroxyanthraquinone type
  - 3. Rhinitis tablets.
- 4. An antinauseant that's also good for motion sickness.
  - 5. An antacid.
  - 6. A tranquilizer.
- 7. An antibiotic-anesthetic throat lozenge.
  - 8. A cough suppressant.
- An intestinal astringent (powder).
  - 10. An antibiotic tablet.
  - 11. An antispasmodic.
  - 12. A potent anodyne.

No quantity packs easier than a dozen. So I place these medications in twelve plastic bottles, each 2½ inches high and 1 inch wide. You might prefer some other size. But use bottles of the same size and shape. The bottle manufacturers send them out of the factory that way—twelve in a cardboard carton.

You can probably get such a carton gratis from your personal pharmacist or through a detail man. It makes a bulky enough and heavy enough package so that you'll always know just where all your medicines are—and that's better than fumbling



prescribe RAUDIXIN to break the mental tension—hypertension cycle



### \*Raudixin reduces mental tension

Tranquilizing Raudixin reduces the mental tension which plays a significant role in hypertension ... reduces mental tension as yet unrelated to physical symptoms.

# \*Raudixin reduces hypertension

Blood pressure lowering effect is gradual, sustained in hypertensives...little or no hypotensive effect is produced in normotensives.

\*Single daily dosage discourages promiscuous overuse by patients...not habit-forming.

# RAUDIXIN

South World Book Rosestia Barreston

SQUIBB



Squibb Quality-the Priceless Ingredient

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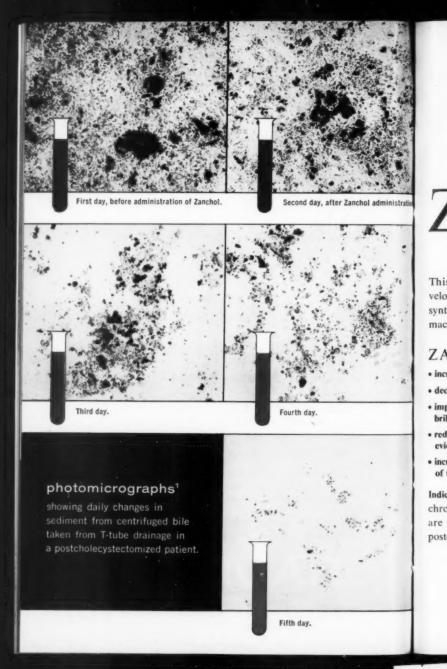
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XUM

# Biliary Abstergent and Hydrocholeretic SC-1674, Now Available as...

# ZANCHOL

(brand of florantyrone)

This newest Searle Research development is a chemically distinct synthetic agent with unique pharmacologic and clinical properties.

### ZANCHOL

- increases volume of bile
- · decreases viscosity of bile
- improves color of bile to a clear, brilliant green
- reduces bile sediment and opacity, as evidenced in T-tube patients
- increases abstergent cleansing action of the bile

Indications: Zanchol is indicated in chronic cholecystitis patients who are not treated surgically; also in postcholecystectomy patients with T-tube drainage, and in prophylaxis and treatment of the "postcholecystectomy syndrome."

Dosage: Dosage will vary with each patient's requirement. However, most patients will respond satisfactorily to a daily dosage of three to four tablets with meals and at bed-time.

Supplied: Zanchol is available as uncoated tablets of 250 mg. each, bottles of 100 and 1.000.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

- \*Trademark of G. D. Searle & Co.
- McGowan, J. M.: Clinical Significance of Changes in Common Duct Bile Resulting from a New Synthetic Choleretic, Surg., Gynec. & Obst. 103:163 (Aug.) 1956.

SEARLE

through odd corners of your luggage looking for odd-sized bottles you've tucked away there.

What about the problem of labeling? You can use ordinary red-bordered stationery labels. Or you can use file labels-the kind that come in strips or rolls. Or you can use perforated address labels. Whatever you use, I suggest that the label show the trade name, the company, the generic name, the tablet size, the dosage, and the indication.

You need the trade name because you'll be more familiar with it under that designation. You'll need the generic name if you want to duplicate it in a foreign country, or if a question of overdosage comes up. For the indication, it's enough to write something like "Tablet after each meal for heartburn" or "Capsule on retiring for dreamless sleep."

### Labels on Top

I always put an abbreviated label right across the top of each bottle. This makes it easy to pick out the exact bottle as soon as you open the carton. Since the cap is only 1 inch across, you have to compress what you want to say down to ten or twelve letters. If you opened the carton in my suitcase, here's what you'd

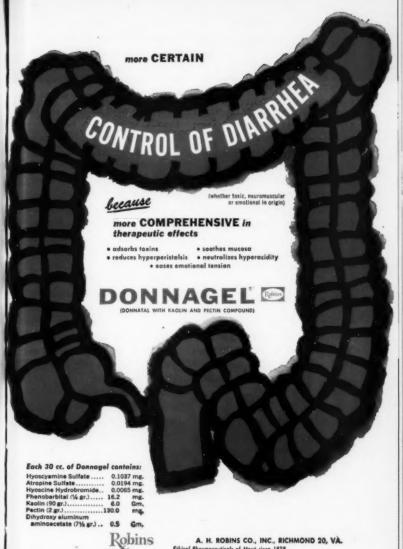
- (1) SOPORIFIC
- (2) LAXATIVE
- (3) RHINITIS
- (4) NAUSEANT
- (5) ANTACID
- (6) CALMATIVE
- (7) LOZENGE
- (8) For Cough
- (9) DIARRHEA (10) ANTIBIOTIC
- (11) SPASMODIC
- (12) A.P.C.

These numerals correspond to the numbers of the dozen listed previously in this article.

One more tip about labeling: Always cover each label-both the side label and the top labelwith some transparent cellulose tape. This keeps the label from peeling off or getting soiled.

The twelve bottles in the carton, plus the ointments and the nasal spray, will give the traveling M.D. something to tide a friend over any common medical complaint, even if he's marooned on a desert island.

My wife also supplements this stock by carrying some items in her cosmetic kit. She doesn't seem sure that modern pharmacology is here to stay. She takes cough drops with her.



A. H. ROBINS CO., INC., RICHMOND 20, VA. Ethical Pharmacouticals of Morst since 1878

MEDICAL ECONOMICS - JUNE 1957 275

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# Office Ownership: Is It Worth the Cost?

[CONTINUED FROM 163]

so. Old patients come in much more frequently than before; many new people out shopping have "just dropped in." The three doctors started with three aides; now they have five and need six.

All this shows up in their practice volume growth—the greatest recorded in the course of our studv. The three doctors' total business before they built (in italics) and immediately afterwards:

1955 practice volume . \$ 87,190 1956 practice volume. 121,650

Note that the business was really there all the time. The doctors just couldn't handle it until they got more help and more space. Then it was relatively easy.

Back in the beginning, we said that office ownership generally results in a more rewarding practice. We mean more rewarding for both doctor and patient.

After all, there's no magic about a new office. The doctor prospers only as he gives good service. It's simply easier for him

to do this when he has exactly the facilities he wants.

An occasional doctor forgets this. He builds but doesn't get exactly the facilities he wants. He skimps to save money, and he's usually sorry later, because he doesn't often get a second chance.

In our observation, doctors who decide to build will run the least risk of disappointment if they build on this basis:

¶ Get the best construction you think you'll be able to afford. In the five states studied, doctors who paid \$20 or more per square foot are still satisfied with the results. Some who paid less than \$15 per square foot aren't.

¶Get enough examining rooms and equip them identically. It may cost \$1,000 extra per room. But depreciated over the equipment's life, that's only about \$8 a month. You come out ahead if the extra equipment enables you to handle three extra patients a month without extra effort. And it normally does.

¶ Get enough help. A welllaid-out new office often justifies one more aide than you've been using. And what you pay out in salaries invariably comes back with interest in higher practice volume. END

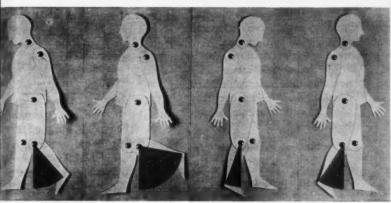
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Effective muscle relaxation for your patients with rheumatic, neurologic and similar conditions

atient, male, age 40, spastic diplegia; physiotherapy and massage previously ineffective. then Tolseram was administered, the following improvement was seen within a month:



left knee, active: from 42° range to 80° range (nearly 100% increase)

right knee, active: from 20° range to 34° range (70% increase)°

FROM ENGLER, M. . J. MENT. SCI. 101:591 (APRIL) 1955

# TOLSERAM

Squibb Mephenesin Carbamate

Tolseram Tablets, 0.5 Gm., bottles of 100, 1000; Tolseram Suspension, 1.0 Gm. per 5 cc. tsp., pints and gallons. Adult dosage: 4 to 6 Tablets or 2 to 3 tsp. Suspension 3 to 5 times daily.

#### Also available:

Tolserol (Squibb Mephenesin) Tablets, 0.25 Gm. and 0.5 Gm., bottles of 100, 1000 Elixir, 0.5 Gm per 5 cr. lsp. pints and gallons. Solution, 20 mg, per cc., 50 and 100 cc. ampuls. Tolserol with Codeine Tablets (0.5 Gm. Tolserol with  $\frac{1}{2}$  gr. codeine), bottles of 100, 1000.

SQUIBB SQUIBB QUALITY-THE PRICELESS INGREDIENT

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# How Do Good Doctors Get That Way?

[CONTINUED FROM 129]

performance. And at this point the researchers began to wonder: Something in the G.P.s' hospital training must have influenced their clinical performance. What was it?

The researchers set off on a new statistical hunt. After much calculation and correlation, they came up with their most significant finding:

#### Training in Medicine

The longer the hospital training IN MEDICINE, the better the doctor. This emerges clearly from the following table, in which Roman-numeral rankings have been averaged in Arabic figures (the higher, the better):

Months of Hospital Training In Medicine	Doctors' Average Rank as Clinicians
More than 8	3.60
5-8	3.31
4	2.81
3	2.63
Less than 3	2.53

By contrast, there seemed to be *no* connection between clinical skill and the length of interneship and residency training in surgery, pediatrics, or obstetrics and gynecology.

Is it possible that this finding was influenced by the make-up and methods of the research team? Were the observers biased in favor of their own specialty, internal medicine? Did they put undue emphasis on diagnostic procedures?

#### **Fairness Defended**

These challenges were anticipated by the researchers themselves. They point out that a given doctor tended to perform each of the six clinical activities studied with about the same degree of competence. Presumably, then, if his skill in delivering babies had been graded, the score would have been similar to the score he made on history taking, for example.

The researchers did evaluate the G.P.s' skill in prenatal care. And they found that the quality of such care "increased directly with the amount of [the doctor's] training in internal medicine." Curiously, length and type of obstetrical training had no apparent effect.

Like all conclusions based on statistical averages, those report-

# Rauwiloid®

# A Better Antihypertensive

"We prefer to use alseroxylon (Rauwiloid)

since it is less likely to produce excessive fatigue and weakness than does reserpine." Up to 80% of patients with mild labile hypertension and many with more severe forms are controlled with Rauwiloid alone.

 Moyer, J.H.: J. Louisiana M. Soc. 108:231 (July) 1956.

# A Better Tranquilizer, too

"...relief from anxiety resulted in generally increased intellectual and psychomotor efficiency with a few exceptions." Rauwiloid is outstanding for its nonsoporific sedative action in a long list of unrelated diseases not necessarily associated with hypertension but burdened by psychic overlay.

 Wright, W.T., Jr., et al.: J. Kansas M. Soc. 57:410 (July) 1956.

**Dosage:** Merely two 2 mg. tablets at bedtime. After full effect one tablet suffices.

# Best first step when more potent drugs are needed

Rauwiloid is recognized as basal medication in all grades and types of hypertension. In combination with more potent agents it proves synergistic or potentiating.

### Rauwiloid®+Veriloid®

In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid (alseroxylon) and 3 mg. Veriloid (alkavervir). Initial dose, 1 tablet t.i.d., p.c.

# Rauwiloid\*+ Hexamethonium

In severe, otherwise intractable hypertension this single-tablet combination provides smoother, less erratic response to hexamethonium. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate. Initial dose, ½ tablet q.i.d.

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ed in this article probably aren't entirely true of any individual doctor. A few of the North Carolina men had been good students and had received good training—but they were still mediocre practitioners. Others had become outstanding doctors despite poor scholastic records and poor training. In addition, though most of the older doctors were rated relatively low, some of them "showed

every evidence of continuing improvement."

These variations can be explained only by "the individual's interest in medicine," the study group concludes.

In the next article in this series, I'll discuss the study group's conclusions about the type and amount of post-graduate study that make for the best brand of general practice.



"No one could possibly recognize you-unless Dr. Abernathy is there."

DEAR DOCTOR,

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"... ultrasonic energy is a physical therapeutic method particularly suited to musculoskeletal dysfunctions, such as osteoarthritis, bursitis, capsulitis, fibrositis, myositis, and periarthritis."

- Editorial Survey: Internat. Rec. Med. and G.P. Clinics 168:803 (Dec) 1955.

Repeated reports of the continuing success of ultrasonic energy in refractory musculoskeletal dysfunctions attest to the established value of this new physical modality.

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# ULTRASONIC THERAPY UNIT

The Burdick Ultrasonic Unit incorporates the rigorous standards of engineering competence which have been the hallmark of fine Burdick physical therapy equipment for 44 years.

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NON-CORROSIVE-NO ANTI-RUST TABLETS TO ADD STABLE-NEED NOT BE CHANGED FREQUENTLY INEXPENSIVE-1 oz. makes 1 gal. of solution

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# Here is the formula for Rexall Super Plenamins





EACH TABLET CONTAINS	11 VITAMINS
Vitamin A Acetate	8000 Units
Visumin Dg (Calciford)	1000 Units
Viremin Br (Thiomine HCI)	2.5 mg.
Visamin Eq	2.5 mg.
Vitamin C	50 mg.
teasinemide	20 mg.
Vitamin Be	0.05 mg.
Vitantin Big (Crystoffine)	3.0 mcg.
Pelis Acid	0.2 mg.
Vitamin E	1.0 mg.
Sinthened Lancacana	3.0 mg.

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(as Ferrous Sulfate, Dried)	15 mg.
Calcium (as Dicalcium Phosphate)	75 mg.
Phosphorus	58 mg.
(as Potassium lodide)	0.15 mg.
Copper	●.75 mg.
Cobalt	0.15 mg.
Manganese	1.25 mg.
Magnesium	10.0 mg.
Molybdenum	0.25 mg.
Potassium	3.0 mg.
Zinc	1.⊕ mg.
Nickel	0.1 mg.

Plus Liver Concentrate, N. F.... 100 mg.

# Rexall Super Plenamins

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A Supplementary Formula of 11 Vitamins and 12 Minerals in One Daily Tablet



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For Further Information and Literature, write: Rexall Drug Company, Vitamin Department, 8480 Beverly Boulevard, Los Angeles 54, California.

MEDICAL ECONOMICS - JUNE 1957 281

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# NEW INTRAMUSCULAR IRON PROVIDES PRECISION THERAPY, PROMPT RESPONSE

IMFERON,® the new intramuscular iron-dextran complex, was introduced to American hematologists at the Sixth International Congress of the International Society of Hematology held in Boston, August 27 to September 1, 1956. Recent experience from over 6 million injections has shown that this iron preparation is easy to administer, notably free from toxic effects, quickly absorbed and productive of rapid hematologic and clinical improvement. It has been termed "... the only therapeutically effective iron preparation for intramuscular use...."

IMFERON meets the need for a safe, effective agent when parenteral iron is preferable for patients with iron deficiency anemia who are resistant or intolerant to oral iron, those with depleted iron reserves and those who require rapid restoration of hemoglobin, e.g., last trimester of pregnancy. Previous parenteral iron preparations were unsatisfactory because of toxicity. pain on injection, or because they contained insufficient iron. IMFERON contains the equivalent of 5 per cent elemental iron. It is more stable than iron saccharate both in vitro and in vivo and does not precipitate in plasma over a wide pH range. It is isotonic with tissue fluids and has a pH of 5.2 to 6.0.1 Utilization for hemoglobin formation is almost quantitative.

Precision Therapy with IMFERON: Before treating a patient with IMFERON, total iron requirement is calculated by formula or determined from a convenient dosage chart. Then appropriate amounts of IMFERON are injected daily or every other day, until the total calculated required amount is given.

Iron Deficiency Anemia of Infancy: IMFERON provides a convenient, safe means for restoring hemoglobin levels and iron reserves in anemic infants. Excellent results were obtained by Gaisford and Jennison<sup>3</sup> with IMFERON in 100 iron-deficient infants. From a pretreatment average of 54.5 per cent. hemoglobin levels rose to 87 per cent 10 weeks after the start of therapy. Clinical improvement paralleled this response. Premature infants and surgical cases were similarly benefited. IMFERON gave "...all the advantages of transfusion or intravenous therapy without the disadvantages."2 There were no side effects in any of the infants treated. Wallerstein<sup>a</sup> confirmed these results, furnishing evidence that IMFERON is well absorbed and appears in the bone marrow 12 to 24 hours after injection. Results are equal to those with intravenous saccharated iron oxide without the unpleasant side effects. Sturgeon\* showed that the first year's iron requirements in infancy can be supplied with three injections of IMFERON.

Iron Deficiency Anemia of Pregnancy: Nausea precludes oral iron therapy in many anemic pregnant women. In those with severe anemia who are first seen late in pregnancy, prompt hemoglobin regeneration is unobtainable with oral iron. IMFERON produced prompt hemoglobin responses in anemia of preg-

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nancy, 5.6 the results being similar to those obtained with intravenous saccharated iron oxide. Side effects were virtually absent with IMFERON. 5.6

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Resistant Hypochromic Anemia: Patients who do not respond to oral iron, those who cannot take oral iron and those with gastrointestinal pathology respond well to injections of IMFERON.<sup>7-11</sup> While oral iron is of little value in treating the anemia of heumatoid arthritis, IMFERON is "...as beneficial as intravenous iron and easier to administer."

Present Studies: Published reports and recent findings of clinical investigators confirm the effectiveness and safety of IMFERON for hemoglobin regeneration and creation of iron stores. More than 70 studies are now being completed in the United States. Reports stress prompt hemoglobin response, ease of administration and freedom from side effects. Clinicians desiring additional information should request Brochure No. NDA 17, IMFERON, Lakeside Laboratories, Inc., Milwaukee 1, Wisconsin.

(1) Brown, E. B., and Moore, C. V., in Tocantins, L. M.: Progress in Hematology, New York, Grune & Stratton, Inc., 1956, vol. I, p. 25. (2) Gaisford, W., and Jennison, R. F.: Brit. M. J. 2:700 (Sept. 17) 1955. (3) Wallerstein, R. O.: J. Pediat. 49:173, 1956. (4) Sturgeon, P.: Pediatrics 18:267, 1956. (5) Jennison, R. F., and Ellis, H. R.: Lancet 2:1245 (Dec. 18) 1954. (6) Scott, J. M., and Govan, A. D. T.: Brit. M. J. 2:1257 (Nov. 27) 1954. (7) Grunberg, A., and Blair, J. L.: A.M.A. Arch. Int. Med. 96:731, 1955. (8) Millard, J. B., and Barber, H. S.: Ann. Rheumat. Dis. 15:51, 1956. (9) Baird, I. M., and Podmore, D. A.: Lancet 2:942 (Nov. 6) 1954. (10) Cappell, D. F.; Hutchinson, H. E.; Hendry, E. B., and Conway, H.: Brit. M. J. 2:1255 (Nov. 27) 1954. (11) Stevens, A. R.: A.M.A. Arch. Int. Med. 96:550, 1956.

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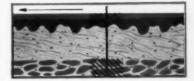
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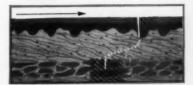
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Pull Skin

**Z-Track Technique** 



Release





# News

[MORE NEWS ON PAGE 14]

# Doctors Warned Against Making Promises

If you ever make a promise to a patient, you're setting yourself up for a lawsuit, Texas doctors have been warned.

Most physicians are aware of this in theory, the Texas State Journal of Medicine concedes. But it points out that there have been quite a few medical breach-of-promise suits lately. Apparently an occasional doctor forgets how easily he can impose upon himself "a greater . . . obligation than the law itself imposes upon him."

A casual word of comfort—if it can be interpreted as a promise to heal—may put the physician in a contractual relationship with his patient, the Journal observes. One result is that he then remains liable to suit for a longer time than otherwise. "The statute of limitations as to breach of contract is longer [than in] a malpractice case," the Journal points out.

Several recent court cases are

cited by the Journal. A Texas court has ruled that "a doctor may contract with a patient to...cure... and if so he is bound by the general rules pertaining to the law of contract."

And New York's highest court has declared that a doctor and his patient are legally at liberty to contract for a particular result and, if the result is not attained, a cause of action for breach of contract results. This is "entirely separate from an action for malpractice," the court said.

### Bicycling Boosted by Paul Dudley White

One of the unexpected results of President Eisenhower's coronary occlusion has been a revival of interest in bicycling—and all because the man who treated the President is a cycling enthusiast.

Dr. Paul Dudley White set things off during a newspaper interview. He said he considered bicycle riding one of the best forms of exer-

# control anxiety in Arthritis, Asthma, Allergic Dermatoses

lower corticoid dosage

the original tranquilizer-corticoid

provides the emotional tranquilizer, ATARAXS (hydroxyzine) and the preferred corticoid, STERANE (prednisolone) . control of emotional factors by tranquilization enhances response to the corticoid for greater clinical improvement . often permits substantial reductions in corticoid dosage. accompanied by reduction of hormonal side effects . confirmed by marked success in 95% of 1095 cases of varied corticoid indications

ATARAXOID now written at

# Ataraxoid *5.0*

and now available as NEW

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advantages: (1) greater flexibility of dosage (2) effective tranquilization permits lower



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# announcing

# **MARSILID**

(Iproniazid)

'Roche'

How does Marsilid act?

Marsilid (iproniazid) is an amine oxidase inhibitor which has a normal eudaemonic\* rather than an abnormal euphoric effect; it promotes a feeling of well-being and increased vitality; it restores depleted energy and stimulates appetite and weight gain in chronic debilitating disorders.

How soon is the effect of Marsilid apparent?

Marsilid is a slow-acting drug. In mild depression it usually takes effect within a week or two; in severe psychotics, results may be apparent only after a month or more.

What are the indications for Marsilid?

Mild depression in ambulatory, non-psychotic patients; psychoses associated with severe depression or regression; stimulation of appetite and weight gain in debilitated patients; chronic debilitating disorders; stimulation of wound healing in draining sinuses (both tuberculous and non-tuberculous); adjunctive therapy in rheumatoid arthritis when associated with depressed psychomotor activity (Marsilid stimulates physical and mental activity, appetite and weight gain without objective joint changes).

\*Eudaemonia is a feeling of well-being or happiness; in Aristotle's use, felicity resulting from life of activity in accordance with reason.

# a psychic energizer

(the opposite of a tranquilizer)

# What is the dosage of Marsilid?

The daily dose should not exceed 150 mg (50 mg t.i.d.). In patients who are not hospitalized, the dosage should be reduced after the first 8 weeks to an average of 50 mg daily or less. Marsilid is a cumulative drug requiring careful individual dosage adjustment.

Side effects due to Marsilid are reversible upon reduction of dosage or cessation of therapy. It may cause constipation, hyperreflexia, paresthesias, dizziness, postural hypotension, sweating, dryness of mouth, delay in starting micturition, and impotence.

# When is Marsilid contraindicated?

Marsilid is contraindicated in overactive, overstimulated or agitated patients. Marsilid therapy should be discontinued two days before the use of ether anesthesia. It should not be given to epileptic patients, or together with cocaine or meperidine.

Marsilid is supplied in scored 50-mg, 25-mg and 10-mg tablets.

MARSILID® PHOSPHATE — brand of iproniazid phosphate (1-isonicotinyl-2-isopropylhydrazine phosphate)

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cise. It stimulates circulation, helps breathing, tones up flabby muscles, gets you out into the fresh air, he said.

After that, things began to happen fast. President Eisenhower specifically mentioned cycling in his message on fitness. Dr. White was invited to open a special bicycling path in Chicago. The editor of the English magazine Cycling came all the way to Boston to write a story. A Paris radiologist was inspired to form an organization of doctors. Amis de la Bicyclette. A German doctor wrote a long scientific article to point out why bicycling was good for the heart. Meanwhile, in



DR. PAUL DUDLEY WHITE, on a whaling trip to California, stops off at La Jolla to enjoy his favorite form of recreation. The man in front is Urologist Robert Boughton. He's one of the dozen or more La Jolla physicians who regularly use bicycles to get to their hospital. They've found that, modern traffic being what it is, bicycles are often faster than automobiles.



\*MODEL DIJ-K PORTABLE HIGH-SPEED AUTOCLAVE

New HIGH in performance New LOW in cost



The newest product of the world's largest manufacturer of Pressure Steam Sterilizers

See your authorized
American Sterilizer Dealer or write
for Bulletin DC-410.

# Compare THESE FEATURES:

- All Stainless Steel
   For durability and easy cleaning
- Positive Sterilization
   Pressure steam at 250° F. to 270° F.
- Greater Capacity
  Holds three large trays (6" x 13")
- Fast
   Reaches 270° F. in approximately seven minutes
- Automatic
- Times any selected sterilizing cycle

  Cool and Dry
- Dries instruments or supplies by exhausting steam and residual water back into water reservoir . . . NOT into room
- Safety-Lock Door, Adjustable Thermostat and Accurate Temperature Gauge Automatically "burn-out" proof



AMERICAN STERILIZER

MEDICAL ECONOMICS · JUNE 1957 28

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A single dose of KYNEX provides then peutic blood levels within the hou Blood concentration peaks are reached within 2 hours—10 mg. per cent blood levels persist beyond 24 hours.<sup>1</sup>

For greater safety: low dosage, his solubility and slow excretion help award crystalluria. For broad antibacterial efectiveness: KYNEX is particularly efficient in urinary tract infections due to sulfonamide-sensitive organisms, including E. coli, Aerobacter aerogenes, para colon bacilli, streptococci, staphylococ Gram-negative rods, diphtheroids and

Gram-p low do offers ance to

Tablets (7½ g Bottles

Syrup: mel-fla sulfam

1. Boge J. M.: (Nov.) 1

\*Reg. U.

# PY WITH A SINGLE (1 gm.) DOSE

Gram-positive cocci. Fer convenience: the low dosage of 1 Gm. (2 tablets) per day offers optimum convenience and acceptance to patients.

**Tablets:** Each tablet contains 0.5 Gm. ( $7\frac{1}{2}$  grains) of sulfamethoxypyridazine. Bottles of 24 and 100 Tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 gm. of sulfamethoxypyridazine. Bottle of 4 fl. oz,

Boger, W. P.; Strickland, C. S.; and Gylfe,
 M.: Antibiot. Med. & Clin. Ther. 3:378 (Nov.) 1956.

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SULFAMETHOXYPYRIDAZINE LEDERLE

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY. \*Rog. U. S. Pot. Off, PEARL RIVER, NEW YORK



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America, bicycles were selling as never before.

Last winter Dr. White went to Southern California in an attempt to get electrocardiographic tracings of the heartbeat of a whale. The trip turned out to be pretty disappointing because the whales would not hold still. But it was by no means a total loss: Dr. White made a stop at near-by La Jolla, went tandeming with a local doctor (see photo on page 288), and probably touched off a new West Coast craze.

# Blue Shield Plan Defends Adequacy of Its Fees

Even if doctors don't ask it out loud, they sometimes wonder about it: "Why are Blue Shield fees so low?" Now the plan in Richmond, Va., has come up with a detailed answer. The real test of the adequacy of Blue Shield fees, it says, is "what the doctor would charge . . . if the patient were paying out of his own pocket."

In the Richmond area, the plan points out, "Blue Shield fees paid under the standard contract must be prepaid by people whose family incomes are less than \$4,000. How much can these people afford to pay for health care? . . . Could these people, without Blue Shield membership, pay larger fees than those currently listed in the standard contract fee schedule?

"To answer these questions, Richmond plan executives consulted officials of two well-known banks, an officer of a reputable finance company, and a social worker of the Family Service Society to get assistance in constructing a practical budget for a man, wife, and two children who are trying to live within an income of ... \$3,900 a year.

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"The following is a condensed composite of the suggestions offered:"

Budget				Annual Amount		
Taxes	(U.S.,	state,	local)	8 270		
Food				1,260		
Housin	g			663		
Clothi	ng			435		
House	operat	tions .		360		
Transp	ortatio	on		300		
Health	care			120		
Contril	bution	s and	gifts .	120		
Childre	en's in	eldent	als	90		
Person	al care			. 54		
Recrea	tion a	nd vac	ation	84		
Life in	suran	e		72		
Miscell	lancou			42		
Tota	d			\$3,900		

Of the \$120 earmarked for health care, the family must pay either \$91.20 (group rate) or \$105.60 (nongroup rate) for Blue Cross-Blue Shield coverage. "Thus," the Richmond plan points out, "there remains \$28.80, maybe only \$14.40... to cover the cost of preventive medical care, office and home care of illness, dental care, dietary supplements, and drugs. Expenses above these amounts can be met only by some

SWIFT RELIEF

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63 35 60 00 20 90 54 84 72 12 00 1 for t pay e) or ) for erage. points naybe e cost office dental , and se asome OF PELVIC SYMPTOMS-FREQUENCY, URGENCY, DYSURIA, STRAINING, SENSATION OF INCOMPLETE EMPTYING; REFERRED PAIN TO ABDOMEN, PELVIS, LUMBOSACRAL REGION, AND UPPER THIGHS; SUPRAPUBIC PAIN

These symptoms are frequently due to an unsuspected urethritis, which yields quickly to FURACIN Urethral Suppositories. Insertion of these suppositories provides gentle dilation; the anesthetic, diperodon, affords prompt and sustained relief of pain. The antibacterial, FURACIN. achieves wide-spectrum bactericidal action without tissue toxicity. Indicated for bacterial urethritis, and for topical anesthesia and prophylaxis of infection before and after instrumentation. Each suppository contains FURACIN 0.2% and 2% diperodon • HCl in a waterdispersible base. Hermetically sealed, box of 12.

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THE RIGHT AMOUNT OF IRON Ferrous Sulfate, U.S.P...... 1.05 Gm. (Elemental Iron-210 mg.)

#### PLUS THE COMPLETE B COMPLEX

BEVIDORAL®.....1 U.S.P. Unit (Oral) (Vitamin B<sub>12</sub> with Intrinsic Factor Concentrate, Abbett)

Liver Fraction 2, N.F200	mg
Thiamine Mononitrate6	mg
Ribofiavin6	mg
Nicotinamide30	mg
Pyridoxine Hydrochioride3	mg
Calcium Pantothenate6	me

#### PLUS VITAMIN C

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sacrifice which this family should not be called upon to make."

The plan's conclusion: "Even with the budgetary help of prepayment, [such] families cannot afford to pay large fees, nor the amounts which, in some communities, are average fees."

### Why One Doctor Breeds Arabian Horses

Some doctors fish, some climb mountains, some collect stamps. And no less than sixty of them breed Arabian horses.

One of the sixty is Orthopedist Edward Parnall of Albuquerque, N.M. Recently MEDICAL ECONOMICS asked him why he breeds Arabian horses. Dr. Parnall's answer may not be entirely typical:

"It all began when I took up the study of Arabic," he explains. "There's a saying of Mohammed: 'If you would draw nigh unto God, love His creatures.' And running into a little book called 'The Arab and His Horse' set me off...

"I began in a modest way," Dr. Parnall continues. "I bought two fine little mares from Dr. Robert E. LaRue of Erie, Ill. Then I bought another horse locally, a stallion. The two mares are now in foal and I hope will produce, insha Allah, two fine colts before long.

"My own ranch is only six and a half acres," he goes on, "but that's enough to feed quite a few Arabian horses. I already had a few common horses, but I sold them when I acquired the more romantic Arabian ones."

So far, Dr. Parnall's sideline hasn't earned him any money. But that doesn't worry him. "Arabians are sold for fairly fancy prices," he points out. "And if you breed a champion, the sky's the limit."

Besides, he says, "my Arabs more than pay for themselves in the pleasure they bring me." He rides about three times a week, with



Dr. Edward Parnall and friend

relaxes both mind and muscle

for anxiety
and tension in
everyday practice

- well suited for prolonged therapy
- m well tolerated, relatively nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to phenothiazine compounds and rauwolfia derivatives
- morally effective within 30 minutes for a period of 6 hours

For treatment of anxiety and tension states and muscle spasm

# Miltown

2-methyl-2-n-propyl-1,3-propanediol dicarbamate— U. S. Patent 2,724,720

Tranquilizer with muscle-relaxant action

DISCOVERED AND INTRODUCED

BY WALLACE LABORATORIES, New Brunswick, N. J.



SUPPLIED: (Bottles 50 tablets) \$00 mg. scored tablets 200 mg. sugar-coated tablets

USUAL DOSAGE: One or two 400 mg. tablets t.i.d.

THE MILTOWN®
MEPROBAMATE MOLECULE

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Relaxes without impairing mental or physical efficiency

...well suited for prolonged therapy 1 "The primary finding of these studies is that meprobamate ['Miltown'] alone ... produces no behavioral toxicity in our subjects as measured by our tests of driving, steadiness and vision."

Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67:701, May 6, 1957.

2 "Since it [meprobamate-'Miltown'] does not cloud consciousness or lessen intellectual capacity, it can be used... even by those busily occupied in intellectual work."

Keyes, B. L.: Pennsylvania M. J. 60:177, Feb. 1957.

"...the patient never describes himself as feeling detached or 'insulated' by the drug ['Miltown']. He remains completely in control of his faculties, both mental and physical ..."

Sokoloff, O. J.: A.M.A. Arch. Dermat. & Syph. 74:393, Oct. 1956.

4 "It ['Miltown'] ... does not cloud the sensorium, and has a helpful somnifacient effect devoid of 'hangover'."

Kessler, L. N. and Barnard, R. D.: M. Times 84:431, April 1956.

"In anxiety and tension states, meprobamate relaxes without dulling cortical function to the same extent as the commonly-used barbiturates."

> Rindskopf, W., Ravreby, M., Gutenkauf, C. and Sands, S. L.: J. Iowa M. Soc. 47:57, Feb. 1957.

# Miltown

2-methyl-2-n-propyl-1, 3-propanediol dicarbamate—U. S. Patent 2,724
TRANQUILIZER WITH MUSCLE-RELAXANT ACTION



SUPPLIED: 400 mg. scored tablets 200 mg. sugar-coated tablets USUAL DOSAGE: One or two 400 mg. tablets t.i.d. Literature and samples available on request

WALLACE LABORATORIES, New Brunswick, N. J.

now ". . . care of the man

rather than merely his stomach."

WOLF A WOLFF HUMAN GASTRIC FUNCTION

Miltown anticholinergic

controls gastrointestinal dysfunction

because it cares for the man

the tranquilizer Miltown in "Milpath" controls the psychogenic element in G. I. disturbances. (Miltown does not produce barbiturate loginess or hangover.)

as well as his 'stomach'

At the peripheral level

the anticholinergic, tridihezethyl iodide, in "Milpath" blocks vagal impulses to prevent hypermotility and hypersecretion.

for duccenal ulcer • gastric ulcer • intestinal colic spectic and irritable colon • ileitis • esophageal spasm G.I. symptoms of anxiety states

prescribe:
1 tablet t.i.d. at
mealtime and

2 at bedtime

"Milpath

Formula:

Miltown® (meprobamate)
400 mg. (2 - methyl - 2 - s propyl-1, 2 - propanediol
dicarbamate)
U. S. Patent 2,724,720
tridihexethyl fodide 25 mg.
(3-diethylamino - 1 - cyclohexyl 1 - phenyl - 1 - propanol-ethiodide)
U. S. Patent 2,598,325

WALLACE LABORATORIES New Brunswick, N. J. Literature and samples on request

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extra early morning training sessions in the summer.

"Too many physicians are on a treadmill," Dr. Parnall comments. His solution: Get off now and then —and get on a horse.

# Kansas Gives Recognition To New-Style D.O.s

A new Healing Arts Act is scheduled to go into effect next month in Kansas. Its novel feature: legal recognition of the fact that there are two kinds of osteopaths—oldstyle and new-style.

The new law continues the usual system of licensure examinations, with M.D.s examining M.D.s, os-

teopaths examining osteopaths, chiropractors examining chiropractors. But—here's the difference—from now on, some osteopaths will also be permitted to take the M.D. examination.

Any D.O. who practiced in Kansas as of Jan. 1, 1957, or who graduated from an approved college of osteopathy after June 1, 1950, will be eligible to be examined by the M.D. members of the licensing board. If he passes, he'll be entitled to call himself an "osteopathic physician and surgeon." He'll then have the same privileges as a doctor of medicine.

If a D.O. isn't eligible for this new status, or if he prefers not to

# for Nausea and Vomiting

# EMETROL

FIRST

(Phosphorated Carbohydrate Solution)

Highly effective when condition is functional; will not mask organic derangement; safe physiologic action...no drug side effects

proved in: epidemic vomiting, functional nausea children, 1 or 2 tsp.; adults, 1 or 2 tbsp.; repeat every 15 minutes until vomiting ceases.

proved in: "morning sickness" - 1 or 2 thsp. on arising; repeat in three hours and whenever nausea threatens.

nausea threatens. In bottles of 3 fl.oz. and 16 fl.oz. so not billute



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try, he'll be examined by the D.O. members of the licensing board. If he passes, he'll be known as an "osteopathic physician"—and he'll be limited to the practice of osteopathy as defined by the Kansas Supreme Court.

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The new law has had the full backing of the state medical and osteopathic associations. The chiropractors have opposed it.

### Crash Program Proposed For Cancer Research

There's a strong likelihood that Congress will soon vote a substantial new subsidy for private cancer research. The reason: Government health experts seem more and more convinced that cancer research is nearing the big pay-off. That's the gist of a special report in Business Week, which adds: "Congressmen are on an economy campaign in other respects, but the glimmer of a cancer cure has them talking about...backing an all-out effort."

If the money's appropriated, according to this report, it will serve to "bolster the pharmaceutical industry's own cancer research and coordinate it with that of the government health agencies." Business Week quotes Federal officials as explaining that so far, "private industry's research has been spotty and relatively small . . . Government



# DOCTOR

This is an announcement

of importance

to your patients

(and of interest to you)

On the page to your right you see the announcement of a new, improved Golden Dial Soap. Exhaustive tests have convinced us that our new synergistic combination makes this an even finer antibacterial deodorant soap than the Dial Soap which you may now be using and recommending.

Complete technical literature will be available soon. In the meantime, our laboratory welcomes inquiries for information and free trial samples. Address Armour and Company, 1355 W. 31st St., Chicago 9, Illinois.

FROM THE LABORATORIES OF ARMOUR AND COMPANY

America's first truly effective deodorant soap is now even better!

# NEW GOLDEN DIAL SOAP STOPS ODOR BETTER THAN EVER!

(milder, too!)



No ordinary soap with "something added" protects you like new Golden Dial!

One look tells you something wonderful has happened to Dal Sosp. One bath tells you much more: New Golden Dai stops odor hetter—better than any other soap you've ever used!

For Golden Dad is me aux another soap with some ingredient added. Dial was forw to be a deodorant soap! Its Super AT.7 was developed especially for Dial. It's more effective than Dial's original AT.7... ewice as effective as any deodorant ingredient in any other deodorant soap.

So, in one bath, new Golden Dial stops odoe better than ever! Removes odor-causing bacteris better than if you scrubbed with any two ordinary soaps. And Golden Dial keeps fighting odor for days?

You get all this with new coameric mildness... smart new wrapper... new golden hard-milled bar. Obviously, such a fine soap coars more to make—costs more to buy than ordinary soap. But it's worth every cent of it!

Especially now -

Aren't you glad you use Dial Soap?

(don't you wish everybody did!)



#### NEWS

scientists...haven't been able to learn much about [its] nature or scope."

The whole subject of new government subsidies "popped up," as Business Week puts it, when the National Cancer Institute was reporting to a subcommittee of the House Appropriations Committee. The subcommittee "began discussing industry's role in cancer research," the report says. "Commit-

#### Add an Extra Room



ARCHITECT: RICHARD LEITCH, PASADENA, CALIF.

You may be able to add an extra room to your office by converting an unused alcove or closet into your sanctum sanctorum. You don't need much space: The 5' x 7' cubbyhole shown here houses everything necessary for dictating, telephoning, and study. Your present consultation room then becomes an additional examining room where you take case histories and treat patients.

Quot a moment, Doctor ...

A MESSAGE TO THE PHYSICIAN
FROM
THE HEALTH NEWS INSTITUTE

#### OVER THE COUNTER

In a certain laboratory in New Jersey there is a technician who would be a cinch to stump the experts on "What's My Line?". Her job? Brushing the teeth of hamsters.

And of course you've already guessed the reason why. This girl is part of the pharmacological phase of new product testing in the field of manufacture. And it's all done on the sound and responsible theory that as a proving ground the enamel of a hamster is less precious than that of your own teeth and the teeth of your patients.

In this case, the product is a dentifrice, a medication in the preventive sense, and at least first cousin to a category of remedies with which you are thoroughly familiar.

Perhaps as recently as yesterday, you said to a patient in your office: "And when you get this prescription filled, buy some of these antacid tablets and take them as I've suggested." Or you may have told a mother over the telephone: "Give him half an aspirin now and again in three or four hours."

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In short, you were recommending products known generically as "proprietary medicines."

By definition, a proprietary medicine or health preparation is one that is manufactured and sold only by the owner of the patent, formula, brand name or trade mark which identifies the product. In the light of recent food and drug legislation, it has come to mean a medicine which may be sold over the counter, i.e., without a prescription. More specifically, however, it is a packaged medicine which is advertised to the public—a home remedy for treating a minor, temporary ailment for which it is indicated.

You are aware of the primary factors differentiating the proprietary from the prescription drugs—the degree to which dosage strength and possible adverse reactions call for your own guidance and experience in administering them.

Almost all new preparations introduced on the market today for use in medicine require a prescription. But if time and usage show them to be safe when the consumer follows package directions, the restriction may be lifted.

It has been said, and rightly so, that if aspirin were discovered today, its label would undoubtedly carry the prescription legend. But years of experience have shown that aspirin, when used in the dosages recommended on the proprietary label, can be taken with safety as an analgesic or antipyretic.

In assessing the safety of any drug, the word "relative" is always used advisedly, for it is doubtful whether any chemical—common table salt or even water, for example—is safe in unlimited quantities.

Alert to the fact that any medicinal preparation must be handled and used with care, proprietary manufacturers are playing a major role in the educational cam-



paign to keep drugs and chemicals out of the reach of children.

The forerunners of today's proprietaries appeared in England during the latter part of the seventeenth century, as remedies whose composition and formulae were protected by patents royal. These "patent medicines" were exported to America in colonial times. In 1796 the first medical patent was granted to Elisha Perkins under the new U. S. Patent Law, and during the nineteenth century the huckster of herbs and nostrums, hawking his wares from the back of a wagon, became a familiar figure in American folklore.

The proprietary industry has come a long way from the "patent medicine" era of a hundred years ago. Federal and State food and drug laws require equal care in the preparation of proprietaries and prescription drugs. The Federal Trade Commission keeps a watchful eye on advertising claims. But more important than law or regulation is the public conscience which motivates the reputable proprietary manufacturer of today.

In the Spring of 1943, for example, adverse reactions following the use of a proprietary preparation brought about unparalleled efforts on the part of its manufacturer to remove the product from the market. The picture of a manufacturer spending several million dollars to tell the public not to use his preparation

was unusual, to say the least, but it reflected a sense of responsibility which has come to characterize the entire industry.

More typical, fortunately for the consumer, is the picture of the manufacturer using all the media of advertising to win acceptance for his product. In order to build a sales volume compatible with a low price, the advertising budget for a proprietary product must be heavy. Several years may go by before the product begins to pay its own way. But carrying it at a loss may be justified, since the life span of a proprietary is probably longer than of a compound in the more rapidly changing prescription field.

Once established, prices of proprietary items tend to change little over the years. Today, identical brands of laxatives and headache remedies cost the same or even less than they did twenty years ago, despite the sharp rise in the cost of living.

On the other hand, new products entering the market necessarily reflect today's soaring costs for research and development. And research is every bit as important with new proprietaries as it is with new prescription drugs, as indeed are the most scrupulous standards for quality control.

Meanwhile, that daily ritual of teeth brushing in the New Jersey laboratory is doing little for the social status of hamsters. But it may have a great deal to do with the dental health and happiness — and social attractiveness — of future Americans.



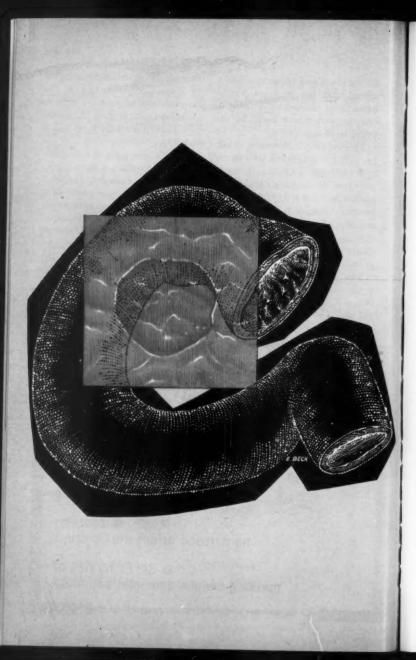
THE HEALTH NEWS INSTITUTE 60 East 42nd Street, New York 17, N. Y. tee members and Institute officials agreed that the program would move faster and more effectively if drug manufacturers could be induced to plunge into it."

This led the subcommittee to ask for industry opinion on how much it would cost "to launch a crash program to develop anticancer chemicals." Ten drug and chemical producers responded. Their consensus: "About \$5,200,000 in Federal funds, to supplement the industry's budget, would get the program started."

The Government is eager to work through private companies, Business Week observes, because the job "is so massive and complex that only the pharmaceutical industry is equipped to handle it. The government doctors don't want to recommend duplicating the industry's facilities except as a last resort."

But the government will duplicate those facilities if the drug industry "continues to drag its heels," the report adds. As a result, drug manufacturers are said to be caught in a squeeze. If they don't cooperate, they'll be faced with "sharply expanding government research facilities." If they do cooperate, they may face "the loss of the tremendously valuable commercial rights that would fall to the discoverer of the long-sought cure."





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# Pro-Banthine® provides rapid control of pain in peptic ulcer

In a two-year study¹ by Lichstein and co-workers, documented by intensive personal observation and by follow-up studies, Pro-Banthīne (brand of propantheline bromide) often brought immediate relief of ulcer pain. Patients (11 per cent) who did not respond satisfactorily to Pro-Banthīne therapy had "anxiety manifestations of psychoneurotic proportions."

In addition to frequent immediate symptomatic relief, Pro-Banthīne reduces gastrointestinal motility and diminishes the secretion and acidity of gastric juice, all-important factors in the generation and aggravation of peptic ulcer.

These actions of Pro-Banthine and its demonstrated effectiveness in accelerating ulcer healing<sup>2-5</sup> mark the drug as a most valuable adjunct in the treatment of peptic ulcer.

The suggested initial dosage is one 15-mg. tablet with meals and two tablets at bedtime. An increased dosage may be necessary for severe manifestations and then two or more tablets four times a day may be prescribed.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

 Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Am. J. M. Sc. 232:156 (Aug.) 1956.

 Sun, D. C. H., and Shay, H.: Arch. Int. Med. 97:442 (April) 1956.

 Rafsky, H. A.; Fein, H. D.; Breslaw, L., and Rafsky, J. C.: Gastroenterology 27:21 (July) 1954.

4. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology 25:416 (Nov.) 1953.

 Silver, H. M.; Pucci, H., and Almy, T. P.: New England J. Med. 252:520 (March 31) 1955.

SEARLE

In this dilemma, they're reportedly working to negotiate a commercial agreement with the Government. Its probable basis, according to Business Week: A Government recognition of the "equities" of any firms in remedies "found through joint effort with Federal agencies."

#### New Emblem Protects Civilian Doctors

If you're active in civil defense, the emblem shown on this page may become pretty familiar to you. The World Medical Association is asking national legislatures to give it formal recognition as the civilian equivalent of the red cross.

By international agreement, medical officers, like other military



personnel, are immune to enemy attack when they display a red cross. But this protection doesn't apply to civilian M.D.s. Until recently, it wasn't thought necessary.

But now, in recognition of the fact that modern warfare can be as hazardous to civilians as to soldiers. the new insigne has been devised.

#### Observer Explains Why Partnerships Fail

While partnership practice has grown steadily more popular, there has also been an increase in the number of partnerships that break up. What makes them fail? Here's the explanation of Theodore Wiprud, long-time secretary of the District of Columbia medical society. who bases his conclusions on "discussions with a number of disillusioned physicians":

The most common complaint, he says, is "incompatibility . . . What usually happens is this: In the first flush of enthusiasm...partners are so taken with each other and their bright prospects that they are oblivious to some of the hard realities of life. Not many months pass before the constant and close association begins to pall. They discover in each other shortcomings which were not apparent in the beginning. Unprepared to make allowances for them, they become impatient and critical . . .

"This unhappy state of affairs," Wiprud continues, "occurs more frequently in two-physician partnerships, especially where one of the partners is a young man and the other much older. Usually, the

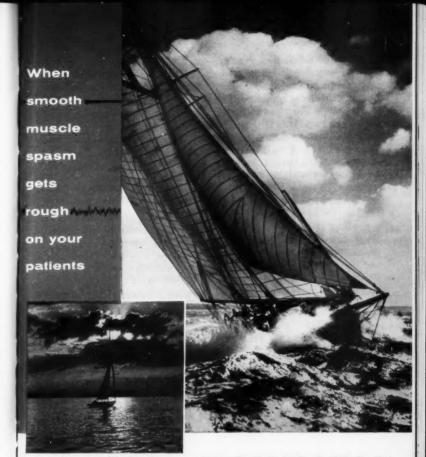
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young man is called upon to carry what he considers more than his share of the burden without commensurate increase in income."

The way to avoid this problem, Wiprud believes, is to start with a trial period of six months to one year. Then, if the two doctors don't hit it off, "their relationship can be terminated without hard feelings."

The second commonest reason why partnerships fail is misunderstanding, Wiprud reports: Too many doctors combine their practices "without taking into account the fallibility of the human mind and the uncertainties of life." He illustrates this with a story of a young doctor whose partner sud-

denly died. Their partnership had been based on an oral agreement. As a result, the surviving physician had to make a highly unfavorable settlement with the senior partner's widow.

This shows, says Wiprud, "the danger of relying upon oral agreements. A written agreement should be drawn by an attorney, preferably one with some experience in the medical field."

His parting advice: "Physicians planning a partnership should realize that it is much like a marriage. In fact, partners often spend more time with each other than they do with their families . . . " Only if they combine practices on a trial basis

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at first—and put their agreement in writing—can they be sure of avoiding "the rocks on which partnerships have most frequently foundered," Wiprud concludes.

#### **Do You Anesthetize Medical Meetings?**

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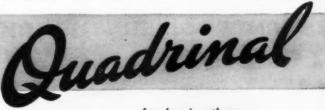
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"If you want to tell a friend about a fishing trip, a golf game, or an interesting medical case, you don't produce a piece of paper from your pocket and proceed to read the facts in a dull monotone. But that," says Dr. William Boyd of Toronto, Ont., "is what so many men do when they find themselves on a platform at a medical meeting...

"The difference between a successful meeting and an unsuccessful one may depend on [a few] easily rectified errors of presentation," he says. For example:

The commonest mistake, he notes, "is to suppose that a paper written for publication is equally suitable for reading to an audience. Nothing, of course, could be farther from the truth. The paper for publication should be filled with detail, both clinical and laboratory... Such a plethora of information cannot be grasped, digested, or remembered by [a listening] audience."

A second common mistake, Dr. Boyd feels, is to read something at



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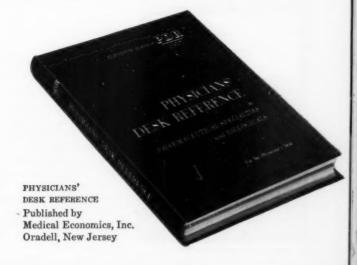
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an audience, instead of speaking to it. He tells of attending a symposium "at which the speakers were of international reputation, each a master of his subject. Before each speaker started I closed my eyes and tried to determine after the first few sentences if he was speaking from notes or reading a manuscript. On opening my eyes, in only one instance did I find that I was wrong."

Are you the sort of speaker who "lowers his head, fixes his gaze on his manuscript, and at the end of twenty minutes looks up with an expression of astonishment that any of his audience are still there"? Or are you the sort who concentrates on avoiding such mistakes? It doesn't take much concentration, Dr. Boyd concludes:

"The art of giving a paper... can be learned very much more easily than the golf swing, to which many of us devote endless hours."

#### Doctors Urged to Fight Unjust Court Awards

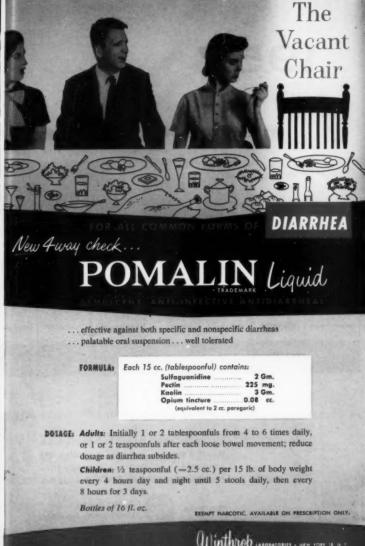
To check the trend toward higher and higher malpractice verdicts, doctors need to change their tactics. That's the opinion of Edwin J. Holman of the A.M.A. law department. "Medicine itself... is reducing malpractice, bad practice, to the irreducible minimum," he points out. But it isn't yet doing enough "to improve the climate in which... claims are presently being considered."

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Here's how Holman explains what he means:

"When we, as citizens, countenance a \$115,000 verdict of malpractice for scars and disfigurements on the breast of a 50-yearold woman ... [when we countenance a] \$105,000 personal injury [award] for the loss of toes on one foot, with no reduction in earning capacity...we are conditioning the public and ourselves to maljustice. We are tolerating unconscionable situations which ultimately rebound to our own harm."

The profession's sense of civic responsibility should lead it to a broad fight to eliminate "even the possibility for such travesty upon the law." Holman suggests: "Every one of us, as a citizen . . . has a duty to bring our concept of justice back to reality." This is clearly something "in which medicine can demonstrate forceful leadership," he concludes.

#### **British Doctors Vote** To Defer Strike

In a surprise turnabout, the British Medical Association has voted to postpone its plan to go on strike against Britain's National Health Service. It has also decided to defer until next month a decision on whether to cooperate with a Government-appointed Royal Commission-a group set up to study the doctors' eighteen-month-old demand for a 24 per cent increase in pay.

Prior to a mid-spring meeting of the B.M.A., the physicians had been prepared to endorse a strong recommendation the B.M.A. Council had made earlier: that G.P.s begin a staggered withdrawal from the N.H.S. next October. The withdrawal had been planned to compel the Government to grant the doctors a pay hike-or at least submit their claim to arbitration.

The doctors had also been expected to back a Council recommendation that they not cooperate with the Royal Commission: It had been set up without their consent, and its recommendations are not binding on the Government.

None the less, it was the B.M.A. Council itself that urged the lastminute turnabout. Why did the medical leaders change their minds? There appear to be several reasons:

First, the physicians were afraid that if they went on strike they might lose whatever public support they had. Second, neither they nor rank-and-file doctors were fully agreed among themselves that they wanted to strike. Third-and most important-the Government had taken action aimed at cooling their anger:

It had granted a 5 per cent pay increase to G.P.s, specialists, and senior hospital staff men. The hike followed a 10 per cent increase to Now...control both
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324 MEDICAL ECONOMICS · JUNE 1957

#### NEWS

junior hospital men. Both are interim awards, designed to keep the M.D.s pacified until the Royal Commission can make recommendations as to what they should be paid.

¶ It had allayed the doctors' early fears that the Royal Commission's terms of reference were so limited that it could "only intensify [a] decline of the professional classes in social and economic status."

Recent conferences between the doctors' chief negotiator and Minister of Health Dennis Vosper "made it quite clear," says the London Times, "that the commission will give the doctors' spokesmen a full and fair hearing... that it has no wish to prolong its proceedings unduly, and that doctors have nothing whatever to lose by arguing their case before this inquiry."

This doesn't mean that all the clouds on the British medical horizon have lifted—not by any means.

The doctors could reject the commission's recommendations. They've made it plain that they're prepared to renew their strike plans if a settlement isn't reached. Meanwhile, the B.M.A. has voted to institute an inquiry into the whole field of medical services—and even to consider alternative schemes to the N.H.S.

Unlike its no-strike decision, this one wasn't unexpected. The British Medical Journal had warned:

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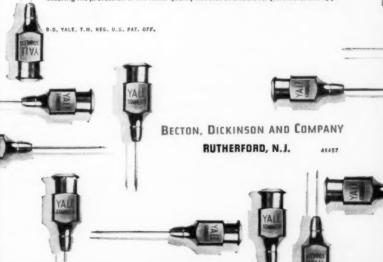
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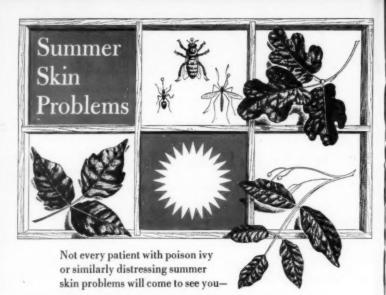
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#### Medical Economics

January to June, 1957

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#### AMERICAN MEDICAL ASSOCIATION

\*What Your A.M.A. Delegates Did in Seattle.

The A.M.A.'s Influence in Congress Is Challenged, Feb. 336

#### **ASSISTANTS**

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MARKS

\*It Pays to Be Available. Jan. 232

Competition for Aides Is Increasing. Feb. 366 Practice Profile: the 'Family' Internist. Apr.

166

\*What Jobs Doctors Delegate-and to Whom. Apr. 131

Who, Me? June 47

#### BIOGRAPHY

Paul, Samuel E., G.P. Dissects Practice in Year-Long Study. Jan. 15

Laws, Clarence L., Hobbies Are This Doctor's Hobby. Feb. 330

Whitehouse, Francis R., M.D. Wins National Fame as Beagle Breeder. Feb. 362

<sup>o</sup>Kupperman, Moses, He Lost His Patients to the Closed-Panel Plans. Mar. 164

Bradfield, James Y., Flying Doctor Declares Planes Save Money. Apr. 364

Russell, Barnett, Tongue Specialist. Mar. 46

Fern, Burton H., M.D. Disabled by Polio Makes a Comeback. Apr. 342

Lehv, Saul P., Surgeon Turns Pastime to Medical Advantage. Apr. 360

Crile Jr., George, Surgeon Operates in Davey Jones' Locker. May 354

\*Emerson Jr., Ernest B., Who Dreams Up the Instruments You Use? May 136

\*Casberg, Melvin A., Surgeon at the Sacrificial Altar. June 230

Parnall, Edward, Why One Doctor Breeds Arabian Horses. June 296

#### CHIROPRACTORS

M.D.s and Chiropractors Reach Unusual Accord. Jan. 17

#### COLLECTIONS AND CREDIT

Collectors' Ethics. Jan. 44

Assignment Forms, Mar. 55

'Charge Slips' Renamed. Mar. 52

'You're to Blame When Patients Don't Pay.' Mar. 14

\*Are You Better Off Than the Typical G.P.? Apr. 246

Practice Profile: the 'Family' Internist. Apr.

MEDICAL ECONOMICS · JUNE 1957



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#### SUBJECT INDEX TO MEDICAL ECONOMICS

°When Should You Sue for an Unpaid Bill? May 159

Heaven Can Wait. June 88

Why People Borrow. June 80

Why Some Collection Letters Don't Collect. June 175

#### DRUGGISTS

Doctor-Owned Pharmacies Still Stir Druggists. Feb. 339

Free Rx Blanks. June 86

#### EDUCATION

Reading Test. Jan. 84

<sup>o</sup>What It Takes to Be a Top Doctor. Jan. 162 Audio-Medical Magazine Becomes Big Busi-

ness. Apr. 351

\*How Do Good Doctors Get That Way? June
124

Post-Graduate Study, June 56

#### EQUIPMENT

OAir-Condition Your Automobile? May 236 Car Dealers Are Ready With Big 'Discounts.'

May 343

\*How You'll Use TV in Your Practice. May 197

"Who Dreams Up the Instruments You Use?

Your Office Needs a Lending Library. May 248

\*Medicine Chest for a Trip Abroad. June 266

#### ESTATE PLANNING

dding

ensive

pplies

ic en-

nerals

is. (1)

When

owed,

TERRA

Oo You Own the Right Life Insurance? Jan. 190

\*How to Save Some Money for Your Heirs. Feb. 108

\*Five Steps to Take Before You Make a Will. Mar. 134

\*Will Your Will Be Done? Apr. 196

Nine Provisions Not to Include in Your Will.
 May 142

\*Ways to Leave Money to Your Heirs. June 212

#### ETHIC5

Accountants Urged to Adopt A.M.A. Code. Jan. 342

Collectors' Ethics. Jan. 44

Life Insurance Reports Called Bad Medicine. Ian. 14

What Your A.M.A. Delegates Did in Seattle. Jan. 138

\*When May You Talk About a Patient? Feb. 101 Doctors Urged to Outlaw Corporate Practice.

Apr. 15

The Doctor's Ideals. May 48

#### EXPENSES

Study Shows How to Cut Fuel Bills. Jan. 328 \*The Woman Doctor's Economic Status. Mar. 126

Flying Doctor Declares Planes Save Money. Apr. 364

<sup>o</sup>How the Specialties Compare Financially. May 115

'Those Damned Dues.' May 85

\*Office Ownership: Worth the Cost? June 150

#### FEE5

\*What Your A.M.A. Delegates Did in Seattle. Jan. 138

When to Charge Less. Jan. 79

How to Explain Witness Fees to the Jury. Feb. 336

Outrageous Fees. Feb. 78

\*Usual Fees in Three Areas. Feb. 134

°Will Medicare Lead to Standardized Fees? Feb. 263

Do Your Fees Reflect Changing Incomes? Mar. 17

How to Make Your Fees Legally Binding. Mar. 20

<sup>o</sup>I Tuilt My Practice Around a Pay-by-the-Year Plan. Mar. 104

Salary vs. Fees. Mar. 53

Surcharges by Physicians Still Causing Trouble, Mar. 364

Practice Profile: 'Family' Internist. Apr. 166 Too Charitable. Apr. 60

Why Cut-Rate Fees? Apr. 84

Fees vs. Values. May 90

French Physicians Fight Fixed-Fee Program.

May 21

All Is Not Gold . . . June 86

Blue Shield Plan Defends Adequacy of Its Fees. June 292

Fees From Polio Shots Go to Medical Schools. June 14

#### **FOREIGN DOCTORS**

British Doctors Blast State Health Service. Feb. 17

How Hungary's Refugee Doctors Are Faring.Feb. 349\*Canada Moves Toward a Federal Health

Plan. Mar. 210

\*British Doctors Press for a Showdown. Apr.

British Doctors Press for a Showdown. Apr 125

French Physicians Fight Fixed-Fee Program. May 21

MEDICAL ECONOMICS - JUNE 1997 333



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#### SUBJECT INDEX TO MEDICAL ECONOMICS

New British Specialty: Taking Night Calls. May 346

British Doctors Vote to Defer Strike. June 320 U.S. Medicine Through a Hungarian's Eyes. June 23

#### GENERAL PRACTICE

G.P. Dissects Practice in Year-Long Study. Jan. 15

G.P.s and Ex-G.P.s. Jan. 42

The G.P.'s Burden. Feb. 54

"Toughest Kind of Practice Today!" Feb. 151
 Why More Doctors Are Going on Salary. Feb. 226

Circumcision Privileges. Mar. 48

The Shifting Balance of Private Medical Practice. Mar. 18

Are You Better Off Than the Typical G.P.? Apr. 246

A.A.G.P. Redefines What a Generalist Is. May

Rural G.P.s Profiled in New Study. May 331 'Greed' of Specialists Rapped by G.P. June

Post-Graduate Study. June 56

#### GRIEVANCE COMMITTEES

Surcharges by Physicians Still Causing Trouble. Mar. 364

#### GROUPS AND PARTNERSHIPS

The Trend Toward Partnerships and Groups. Jan. 18

\*How They Fare in Partnerships and Groups. Mar. 122

\*Rx for a Freer Life: Get a Partner! May 128 Observer Explains Why Partnerships Fail. June 310

#### HEALTH INSURANCE

Blue Shield Said to Be 'Robbing Surgeons.' Jan. 20

Dental Insurance Plan Boosts Its Benefits. Jan. 316

Welfare Rebuttal. Jan. 46

What Your A.M.A. Delegates Did in Seattle. Jan. 138

British Doctors Blast State Health Service. Feb. 17

Health Insurance Query. Feb. 80

Health Plans Are Warned: 'Work Together or Else,' Feb. 14

Physicians Forum Tries a New Approach. Feb. 20

Assignment Forms. Mar. 55

Canada Moves Toward a Federal Health Plan. Mar. 210 Dingell Takes Up Where Father Left Off. Mar. 360

Government's New No. 1 Physician Takes Over, Mar. 15

<sup>o</sup>He Lost His Patients to the Closed-Panel Plans. Mar. 164

\*Is Reuther Bluffing Medicine? Mar. 130

Should the Patient 'Profit' From Sickness? Mar. 268

Surcharges by Physicians Still Causing Trouble. Mar. 364

Administration Sets Goals for the Health Plans. Apr. 342

'Blue Shield Must Cover Out-patient Studies.'
Apr. 14

British Doctors Press for a Showdown. Apr. 125

Closed-Panel Sobs. Apr. 54

Cut Off Surgeons? Apr. 48

Health Insurance Goal. Apr. 90

Physicians Break With U.M.W. Health Plan. Apr. 349

Why Cut-Rate Fees? Apr. 84

Workers Choose Between Two Health Plans. Apr. 20

Four Problems That Medicine Must Solve. May 146

French Physicians Fight Fixed-Fee Program. May 21

"Halfway' Health Plans Aren't Enough! May 131

How to Provide the Aged With Health Insurance. May 334 Labor Leader Says M.D.s Stymie Prepayment.

May 350
\*Local Blue Shield Plans Meet a National

Challenge. May 212

\*What Some M.D.s Think of Closed Panels.

May 177

Blue Shield Plan Defends Adequacy of Its Fees. June 292

#1 Insurance. June 81

Multiple Insurance. June 46

"Why Can't Blue Cross Cover Mental Ills?" June 17

#### HOSPITALS

Homeless Patients Being Moved From Hospitals. Jan. 340

Hospital Doctors Get Their Own Colors. Jan. 343

\*Hospitals Sign Peace Pact With M.D.s Jan. 286.

\*How We Licked Our Hospital Bed Shortage. Jan. 216

MEDICAL ECONOMICS JUNE 1957 335



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336 MEDICAL ECONOMICS · JUNE 1957

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M

Liability Insurance Worries Hospitals. Jan. 319 Patronize the Hospital That's Unionized.' Jan. 314

'Residents Usurp Cases From Young Surgeons.' Jan. 326

Rx for Hospitals: More Males. Jan. 319

What Your A.M.A. Delegates Did in Scattle. Jan. 138

\*Are Your Hospital Rights Well Protected? Feb. 130

Hospital 'Dictatorship.' Feb. 54

'V.A. Hospitals a Boon,' Claims Local Observer. Feb. 344

Circumcision Privileges. Mar. 48

Do Proprietary Hospitals Give Good Service? Mar. 362

Hospital Staff Standards. Mar. 79

Lay Hospital Boards Are Called Outmoded. Mar. 14

'Blue Shield Must Cover Out-Patient Studies.' Apr. 14

Hospital Relations. Apr. 49

More Money, More M.D.s for Mental Hospitals. Apr. 20

°Is Your Hospital Up to Par? June 111

New Rules for Staff Meetings. June 20 Staff Speakers Only? June 52

The Truth About Unnecessary Operations. June 197

#### **HUMOROUS COMMENTARY**

Human Nature Chart. Mar. 43

So You Think You've Got Troubles! Mar. 257

\*Taking a Vacation, Hmm? June 118

#### INCOMES

de

Doctors' Earnings. Jan. 44

Low Pay in Industrial Medicine Assailed, Jan. 19

Doctors' Earnings. Feb. 47

Take-Home Pay. Feb. 84

\*Why More Doctors Are Going on Salary. Feb. 226

Do Your Fees Reflect Changing Incomes? Mar. 17

Salary vs. Fees. Mar. 53

Spotlight on the Salaried Doctor. Mar. 118
 The Woman Doctor's Economic Status. Mar.

The Woman Doctor's Economic Status. Mar.
 126
 Are You Better Off Than the Typical G.P.?

Apr. 246

\*Practice Profile: the 'Family' Internist. Apr.

\*How the Specialties Compare Financially. May 115

#### INDUSTRIAL MEDICINE

Low Pay in Industrial Medicine Assailed. Jan. 19

 Industry Offers You Part-Time Opportunities, Feb. 292

Industrial Practice on a Fee-for-Service Basis.

Mar. 350

#### INSURANCE

Do You Own the Right Life Insurance? Jan. 190

Life Insurance Reports Called Bad Medicine.

Jan. 14

'Overhead Insurance.' Jan. 52

Painless Bill-Paying? Well, Almost. Jan. 16

Can You Pass This Insurance Test? Feb. 280 Tough Dilemma Seen in Insurance Work.

Feb. 15

OWbat Price Malpractice Insurance? Apr. 120 New Code Governs Exams For Liability Lawsuits. May 336

When to Say No. May 88

#1 Insurance. June 81

#### INVESTMENTS

Big Returns Offered to Small Investors, Jan. 325

1957 Economic Outlook: Mild Readjustment. Jan. 312

New Laws Ease Stock Gifts to Children. Jan. 127

"The Doctor's Nest Egg. Jan. 118

How Fast Have the Growth Funds Grown? Feb. 19

Should You Buy a Farm as an Investment? Feb. 200

\*How to Cut Taxes on Investment Income. Mar. 309

<sup>o</sup>Try Investing Semi-Automatically. Mar. 192 Even Professionals Pick the Wrong Stocks. Apr. 356

Should You Switch Savings Bonds? Apr. 358 The Best and Poorest Performers on the New

York Stock Exchange in 1956. Apr. 18

\*How to Hedge When the Market's on Edge.

May 125 Physician-Farmers, May 57

Can You Pass This Business Quiz? June 145

#### LABOR UNIONS

'Patronize the Hospital That's Unionized.' Jan. 314

\*Is Reuther Bluffing Medicine? Mar. 130 Closed-Panel Sobs. Apr. 54

Physicians Break With U.M.W. Health Plan. Apr. 349

MEDICAL ECONOMICS · JUNE 1957 337



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338 MEDICAL ECONOMICS JUNE 1957

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Workers Choose Between Two Health Plans.

Labor Leader Says M.D.s Stymie Prepayment. May 350

Drunken Drivers Curbed by M.D.-Sponsored Law. Jan. 332

Newest in Pocket Books: a Medicolegal Reader. Jan. 338

New Help for the Medical Witness. Jan. 130 New Laws Ease Stock Gifts to Children. Jan.

How to Explain Witness Fees to the Jury. Feb. 336

"When May You Talk About a Patient? Feb. 101

\*Five Steps to Take Before You Make a Will. Mar. 134

How to Make Your Fees Legally Binding. Mar. 20

\*Will Your Will Be Done? Apr. 196

M.D.s Fined for Failing to File Forms on Time. May 331

New Code Governs Exams For Liability Lawsuits. May 336

Nine Provisions Not to Include in Your Will. May 142

When Should You Sue for an Unpaid Bill? May 159

\*Are You Training Future Competition? June

Doctors Urged to Fight Unjust Court Awards. June 316

Doctors Warned Against Making Promises. June 284

"How Long Before You're Safe From Suit? June 164

#### LEGISLATION

Disciplinary Board Begins Policing Doctors. Feb. 186 Physicians Forum Tries a New Approach. Feb.

The A.M.A.'s Influence in Congress Is Challenged, Feb. 336

Dingell Takes Up Where Father Left Off. Mar. 360

Disciplinary Board. Mar. 43

Government's New No. 1 Physician Takes Over. Mar. 15

Administration Sets Goals for the Health Plans. Apr. 342

Disciplinary Board, Apr. 58

Congress Writes Off the Special Doctor Draft. June 16

Kansas Gives Recognition to New-Style D.O.s. June 298

#### LOCATION AND DISTRIBUTION

\*U.S. Physicians: Where They're Locating.

How the Sears-Roebuck Fund Helps M.D.s. Feb. 328

Foundation Grants Loans for Medical Setups. Mar. 366

"How I Found the Ideal Place to Practice. Apr.

<sup>o</sup> Jobs in Search of Doctors. Apr. 143

Two Towns Fight Over Who Gets Doctor. May 340

More Specialists Are Moving to Smaller Places. June 18

#### MALPRACTICE

Liability Insurance Worries Hospitals. Jan.

The Case of the Outmoded Blood Test. Jan. 114

Malpractice Rx. Feb. 47

Malpractice Rx Reduced to Just 61 Words. Feb. 14

The Case of the Missing Evidence. Feb. 112 "But Suppose the Patient Sues . . . ' Mar. 202

The Case of the Unread X-Ray, Mar. 114

OWhen You Make a Mistake. Mar. 236 How to Cope With a Malpractice Threat. Apr. 17

Malpractice Money-Saver. Apr. 85

oThe Case of the Improved Record. Apr. 140 °What Price Malpractice Insurance? Apr. 120

"Call a Consultant-and Avoid a Lawsuit." May 228

Editor Attacks 'Shotgun' Malpractice Suits. May 22

Telephone Trap. May 89

The Case of the Merry Widow, May 174 Doctors Urged to Fight Unjust Court Awards. June 316

"How Long Before You're Safe From Suit? **June 164** 

The Case of the Well-Meant Quip. June 143

MEDICAL COSTS

The Real Cost of OB Care Is Down. June 140

#### MEDICAL ECONOMICS' 8th SURVEY

The Doctor's Nest Egg. Jan. 118

\*Yardstick for Your Practice. Jan. 117, Feb. 115, Mar. 117

\*Doctors' Working Hours. Feb. 116

<sup>o</sup>How Your Patient Load Compares. Feb. 122

MEDICAL ECONOMICS · JUNE 1957 339

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340 MEDICAL ECONOMICS - JUNE 1957

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<sup>o</sup>How They Fare in Partnerships and Groups.

\*Spotlight on the Salaried Doctor. Mar. 118 o'The Woman Doctor's Economic Status. Mar.

Are You Better Off Than the Typical G.P.? Apr. 246

oHow the Specialties Compare Financially. May 115

#### MEDICAL SCHOOLS

Survey Pinpoints Needs of Medical Students.

Government's New No. 1 Physician Takes Over. Mar. 15

'Ten Best Schools,' Mar. 42

Pressure on Our Schools. May 84

Fees From Polio Shots Go to Medical Schools. June 14

#### MEDICAL SOCIETIES

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Drunken Drivers Curbed by M.D.-Sponsored Law. Jan. 332

'It Can Happen to the Most Successful M.D.' Ian. 320

M.D.s and Chiropractors Reach Unusual Accord. Jan. 17

Two States Say No to 'Medicare.' Jan. 318 Co-Ops Claim Gains Over Organized Medi-

cine. Feb. 16 Doctors Set Up Laymen's Advisory Committee. Feb. 340

Non-Participation Up For Doctors' Vote. Feb.

<sup>o</sup>Medical Meetings in Europe. Mar. 293

Profession's Protector. Mar. 86

"We Pack 'Em In at Our Medical Meetings.' Mar. 144

A.C.S. Asked to Curb Its Leading Spokesman. Apr. 15

\*Are They Wasting Your Dues Dollars? Apr. Audio-Medical Magazine Becomes Big Busi-

ness. Apr. 351 Parliamentary Procedure At a Glance. Apr.

Doctors Found Sicker Than Expected. May 14

Medical 'Cavalcade.' May 49 'Those Damned Dues.' May 85

Do You Anesthetize Medical Meetings? June

Fees From Polio Shots Go to Medical Schools. June 14

#### MILITARY MEDICINE

°Is 'Medicare' Good for Medicine? Jan. 259 Two States Say No to 'Medicare.' Jan. 318 What Your A.M.A. Delegates Did in Seattle.

Reactions to 'Medicare.' Feb. 50

\*Will Medicare Lead to Standardized Fees? Feb. 263

Medicare Chief Explains What 'Elective' Means. Apr. 353

'Third-Party' Medicine. Apr. 58 Multiple Insurance. June 46

#### OFFICES

Foundation Grants Loans for Medical Setups. Mar. 366

OA Budget Building That's Rich in Extras. May 154

Add an Extra Room. June 302

Office Ownership: Is It Worth the Cost? June 150

#### OSTEOPATHS

Kansas Gives Recognition to New-Style D.O.s. **June 298** 

#### PATIENT RELATIONS

Christian Scientists. Jan. 52

How Convenient Are You? Jan. 82

oIt Pays to Be Available. Jan. 232

Life Insurance Reports Called Bad Medicine. Jan. 14

'Medical Passport' Is Catching On. Jan. 317 <sup>o</sup>Medicine's Seven Deadly Sins. Jan. 104 Talking and Listening. Jan. 50

Decisions They Want You to Make. Feb. 168 Foolproof Follow-Ups. Feb. 80

Doctor Chides Colleagues on Medical Manners. Mar. 347

Human Nature Chart. Mar. 43

Physicians Urged to Write Postoperative Letters. Mar. 354

When You Make a Mistake, Mar. 236

You've Got to Switch Your Roles. Mar. 240 <sup>o</sup>How to Educate Patients to Parenthood. Apr. 214

'Old-Fashioned Hogwash.' Apr. 87

Patients' Decisions. Apr. 49

Practice Profile: the 'Family' Internist. Apr. 166

Clinic Courtesy. May 86

Unwelcome Patients. May 52

\*Ways to Preserve the Personal Touch. May

\*Your Office Needs a Lending Library. May

Doctors Warned Against Making Promises. June 284

"How to Get People to Accept Your Advice. June 242

MEDICAL ECONOMICS - JUNE 1957 341

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Should You Tell Patients the Truth? June 130

Ten-Cent Bargain. June 82

<sup>o</sup>Tips on Talking With the New Patient. June 222

Voice With a Smile? June 84

#### PRACTICE MANAGEMENT

How Convenient Are You? Jan. 82 \*It Pays to Be Available. Jan. 232

\*Split Your Medical and Financial Records!

Jan. 179

\*Doctors' Working Hours. Feb. 116

Foolproof Follow-Up., Feb. 80

OHOW Your Patient Load Compares. Feb. 122
The G.P.'s Burden. Feb. 54

Breaking the Hurry Habit. Mar. 78

<sup>o</sup>I Built My Practice Around a Pay-by-the-Year Plan. Mar. 104

Medicine's 'Sins.' Apr. 48

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Practice Profile: the 'Family' Internist. Apr. 166

What Jobs Doctors Delegate—and to Whom. Apr. 131

\*What's Your Practice Worth? Apr. 148

<sup>o</sup>How Do Good Doctors Get That Way? May 164

\*How You'll Use TV in Your Practice. May 197

\*How to Get People to Accept Your Advice. June 242

Mail Call. June 80

Office Ownership: Is It Worth the Cost? June 150

Voice With a Smile? June 84

#### PRIVATE LIVES OF DOCTORS

Are You Better Off Than the Typical G:P.? Apr. 246

\*Now's the Time to Plan Your Vacation. Apr. 296

M.D. Warns Colleagues About Drug Addiction. May 15
 Taking a Vacation, Hmm? June 118

#### PROFESSIONAL RELATIONS

<sup>o</sup>Medicine's Seven Deadly Sins. Jan. 104

What It Takes to Be a Top Doctor. Jan. 162
 Are Your Hospital Rights Well Protected?
 Feb. 130

Disciplinary Board Begins Policing Doctors.
 Feb. 186

Doctor Chides Colleagues on Medical Manners. Mar. 347

Hospital Staff Standards. Mar. 79

\*Why Some Specialists Get More Referrals. Mar. 222 How Women M.D.s Differ (In Practice) From Men. Apr. 364

Malpractice Money-Saver. Apr. 85

Medicine's 'Sins.' Apr. 48 Grave Question. May 61

O'Call a Consultant—and Avoid a Lawsuit.' May 228

What Some M.D.s Think of Closed Panels. May 177

\*Are You Training Future Competition? June 182

Delayed Exposure. June 81

\*Is Your Hospital Up to Par? June 111

Kansas Gives Recognition to New-Style D.O.s. June 298

New Rules Set for Staff Meetings, June 20
\*The Truth About Unnecessary Operations,
June 197

Who Gets Referrals. June 48

#### PUBLIC HEALTH

What Your A.M.A. Delegates Did in Seattle. Jan. 138

Fluoridation Failure. Feb. 48

\*M.D.s' Mortality: Better Than You Think. Mar. 111

How to Fluoridate? Apr. 60

Doctors Found Sicker Than Expected. May 14

\*Four Problems That Medicine Must Solve.

May 146

M.D. Loses Suit Against Pro-Fluoridationists. May 17

M.D. Warns Colleagues About Drug Addiction. May 15

Polio Foundation Said to Mislead Doctors. May 348

Crash Program Proposed for Cancer Research. June 299

New Emblem Protects Civilian Doctors. June 310

#### PUBLIC RELATIONS

\*Medicine's Seven Deadly Sins. Jan. 104 Doctors Set Up Laymen's Advisory Committee. Feb. 340

Ophthalmologists Plan Publicity Campaign. Feb. 350

Radiologists' P.R. Mar. 46

Two Country Doctors Get Spectacular Publicity. Mar. 18

A.C.S. Asked to Curb Its Leading Spokesman. Apr. 15

\*Are They Wasting Your Dues Dollars? Apr. 224

Medicine's 'Sins.' Apr. 48

'Old-Fashioned Hogwash.' Apr. 87

Medical 'Cavalcade.' May 49

MEDICAL ECONOMICS · JUNE 1957 343



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Salar \*Spo \*Job

Ja

F

F

ti

16

M

M

Bicycling Boosted by Paul Dudley White. June 284

#### RECORDS

'Medical Passport' Is Catching On. Jan. 317 Split Your Medical and Financial Records! Jan. 179

Telephone Message Form Speeds Diagnosis. Feb. 334

Assignment Forms. Mar. 55

'Charge Slips' Renamed. Mar. 52

The Case of the Improved Record. Apr. 140

Crash Program Proposed for Cancer Research. June 299

#### RETIREMENT

'It Can Happen to the Most Successful M.D.' Jan. 320

Can You Expect a Pension Tax Break? Apr. 115

#### SOCIAL SECURITY

Social Security, Feb. 46

Dingell Takes Up Where Father Left Off. Mar. 360

#### SPECIALISM

ly

or

le.

re

nt

20

nc

ed

e-

al

d;

g.

ac

le

at

Blue Shield Said to Be 'Robbing Surgeons.' Jan. 20

G.P.s and Ex-G.P.s Jan. 42

Private Doctors Offier Supervoltage X-ray. Jan. 334

Internist's Plight. Feb. 46

Ophthalmologists Plan Publicity Campaign. Feb. 350 Why More Doctors Are Going on Salary.

Feb. 226

Radiologists' P.R. Mar. 46

The Shifting Balance of Private Medical Practice. Mar. 18

Cut Off Surgeons? Apr. 48

Practice Profile: the 'Family' Internist. Apr.

\*Four Problems That Medicine Must Solve. May 146

<sup>o</sup>How the Specialties Compare Financially. May 115

'Greed' of Specialists Rapped by G.P. June 14

#### SPECIAL TYPES OF PRACTICE

"Why More Doctors Are Going on Salary. Feb. 226

Salary vs. Fees. Mar. 53

\*Spotlight on the Salaried Doctor. Mar. 118 \*Jobs in Search of Doctors. Apr. 143

What Some M.D.s Think of Closed Panels. May 177

Doctors on Salary. June 52

\*Surgeon at the Sacrificial Altar. June 230

#### TAXES

New Laws Ease Stock Gifts to Children. Jan. 127

Pheasant-Hunting M.D.s Organize Seminar.

Relax-It's Deductible! Jan. 78

<sup>o</sup>Tax Savings via Personal Deductions. Jan.

"What You Don't Know About Your Taxes. Jan. 97

<sup>o</sup>Your 1957 Tax Timetable, Jan. 112

 Answers to Your Income Tax Questions. Feb. 252

<sup>o</sup>How to Save Some Money for Your Heirs. Feb. 108

Tax Break Ahead? Feb. 79

Tax Morality, Feb. 50

Costliest Tax Mistakes. Mar. 84

<sup>o</sup>How to Cut Taxes on Investment Income. Mar. 309

\*See How You Rate on This Tax-Savings Test. Mar. 99

The Tax Errors You're Most Likely to Make. Mar. 176

\*Can You Expect a Pension Tax Break? Apr.

Pheasant Hunters. Apr. 58

"You can Deduct the Damnedest Things! Apr. 280

#### VETERANS ADMINISTRATION

They're Checking Up on Veterans' Pensions. Ian. 338

What Your A.M.A. Delegates Did in Seattle. Jan. 138

M.D.s Threaten Boycott Against V.A. Hospital. Feb. 354 'V.A. Hospitals a Boon,' Claims Local Ob-

server. Feb. 344

V.A. Cuts Red Tape in Home-Town Care. Mar. 22

Is the V.A. Devaluing Home-Town Care? Apr. 368

#### WRITING AND SPEAKING

Pronounced Opinions. Jan. 43

'Semantic Malpractice' Draws Hawley's Ire. Feb. 328

Tongue Specialist. Mar. 46

Do You Anesthetize Medical Meetings? June

'English Murder' Case. June 58

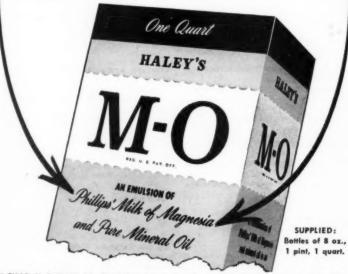
MEDICAL ECONOMICS · JUNE 1957 345



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### **Index of Advertisers**

Abbott Laboratories	Carnrick Company, G. W.,
Desoxyn	Bontril 221
Harmonyl 258, 259	Castle Co., Wilmot,
Iberol	Autoclave "999"
Optilets 4	Central Pharmacal Company, The,
Placidyl   Insert between 82, 83	Biotres 48
	Neocyten 88
American Cyanamid Company	Uritral 206
Folic Acid	Cereal Institute, Inc.
American Felsol Co.	Institutional
Felsol 219	Ciba Pharmaceutical Products, Inc.
American Ferment Co., Inc.	Antivy Lotion
Caroid & Bile Salts 44	Nupercainal 108
American Medical Education	Serpasil (all forms) Insert between 32, 33
Foundation	Trasentine-Phenobarbital 72
American Sterilizer Company	Vioform Hydrocortisone Cream 196
Model 613-R Portable High Speed Autoclave 289	Clay-Adams Company, Inc. Kahn Uterine Trigger Cannula 328
Autociave	
Ames Company, Inc. Clinitest 36	Colwell Publishing Co.
Clinitest 36 Clinistix 23	Professional Stationery and Record
Decholin 226	Supplies 324
	Comptometer Corp. Comptometer Commander
Nostyn 62	Comptometer Commander 13
Armour & Company Golden Dial Soap 300, 301	Desitin Chamical Company
A server I shoretoning	Desitin Chemical Company
Armour Laboratories Chymar 207	Desitin Ointment 25
	Drew Pharmacal Company Zilatone Tablets
Arnar-Stone Laboratories	Zilatone Tableta 84
Americaine Topical Anesthetic Oint-	P-t W-1-1 C
ment & Aerosol	Eastman Kodak Company Kodak K-300 Projector 188, 189
Xvlocaine Viscous 203	Kodak K-300 Projector 188, 189
	Eaton Laboratories
Aveeno Corporation Aveeno Colloid Baths 252	Furacin Urethral Suppositories 293
	Furadantin 334
Ayerst Laboratories	Tricofuron 174
Mediatric	Endo Laboratories, Inc. Percodan
Ayerst Laboratories Mediatric Premarin w/ Methyltestoste- rone Mediatric 264	
methyltestoste-	Esta Medical Laboratories, Inc. Lanteen Exquiset
Your /	Frencet & Jennings Inc
Mediatric	Everest & Jennings, Inc. Wheel Chairs
Battle & Company	Wheel Chairs
Papine (Battle)	Fleet Co., Inc., C. B.,
Bauer & Black (Div. of the Kendall Co.)	Fleet Enema Disposable Unit
51 Gauge Elastic Stockings 37	Florida Citrus Commission
Bausch & Lomb Optical Company	Frozen Citrus 45
Medical Set 98	Frozen Citrus 45 Fougera & Company, Inc., E.,
Baxter Laboratories	Diasal
Plexitrom Controlled Volume Unit 28	D(0.00)
Becton, Dickinson & Company	General Electric Company, X-Ray Dept.
B-D Yale Hypodermic Needles 329	Patrician
Beech-Nut Life Savers, Inc.	Gerber Products Co. Meat Base Formula 56
Apple Sauce	Meat Base Formula 56
Dilhuher Knoll Corn	Geigy Chemical Co.
Bilhuber-Knoll Corp. Quadrinal	Preludin109
Quadrinal 318 Birtcher Corporation, The,	
Hyfrecator	Hamilton Mfg. Company
Borden Company	Steeltone Professional Furniture 195
Borden Company	Health News Institute 303, 304, 305, 306
Bremil   Insert between 48, 49	Heinz Company, H. J.
Mull-Soy )	Junior Breakfast 32
Bristol-Myers Company Bufferin 60	Hoffmann-LaRoche, Inc.
Bufferin	Azo Gantrisin 68
Service & Equipment 39	Azo Gantrisin         68           Lipo Gantrisin         Insert between 178, 179           Marsilid         286, 287           Tashan Cream         94
	Marsilid 286 287
Burroughs Wellcome & Co. Cortisporin 63	Tashan Cream 94
	Holland-Rantos Company, Inc.
Burton Manufacturing Co.	Holland-Rantos Company, Inc. Koro-Flex 22
Information Sources for Diagnosis 328	
Camp & Company, S. H.,	Irwin, Neisler & Company
Braces 238	Obocell 208

Binding covered by U.S. patent No. 2,193,534

#### INDEX OF ADVERTISERS

Johnson & Johnson		National Drug Company, The,
Johnson's Medicated Powder	250	AVC Improved 260
		Hesper-C 342
Kinney & Company		Parenzyme 187
Coactyn	200	Nepera Laboratories Div.
		Cholarace 30
Emetrol	420	Nion Corporation
		Calcinatal 92
Lakeside Laboratories, Inc.		Nu-Lift Company, Inc. Maternity Support 190
	2. 283	Maternity Support 190
Imferon 283 Lavoris Company, The, Lavoris Lederle Laboratories	.,	Ortho Pharmaceutical Corp. Delfen Vaginal Cream 103
Lavoris	261	Ortho Pharmaceutical Corp.
Lederle Laboratories		Delfen Vaginal Cream 103
Achrocidin Achromycin V	101	Parke, Davis & Company
Aureomycin 248	249	Ceiontin Kapseais
Incremin	915	Celontin Kapseals Dilantin Milontin Phelantin
V	201	Milontin
Kynex 290	201	Phelantin /
Pathibamate Insert between 320	1, 321	Parer Laboratories, Div. of Chas, Parer
Pathibamate 321, 322	2, 323	& Co., Inc.
Revicaps	100	Ataraxoid 285
Leeming & Co., Inc., Thos., Metamine Sustained		Bonamine 336
Metamine Sustained	246	Combiotic 31
Lever Brothers Company		Neo-Magnacort 178, 312
Lever Brothers Company Lifebuoy	325	Sigmamyein 349
Lifebuoy Lewal Pharmaceutical Co. Hydrolamins		Bonamine   336
Hydrolamins	38	Sterane 201 Phillips Co., The Chas. H.,
Lilly & Company, Eli, Co-Pyronil 231, 232 Crystodigin Elorine Chloride 9		Phillips Co. The Chas. H.
Co-Pyronil 231, 232	. 233	Phillips Co., The Chas. H., Haley's M-O 346 Physicians' Desk Reference 314, 315 Picker X-Ray Corporation
Crystodigin	239	Dhysicians' Dock Deference 914 915
Elorine Chlorida 9	0 91	Physicians Desk Reference 314, 313
Mi-Cebrin	52	Picker A-Ray Corporation
Mi-Cebrin	90	"Anatomatic" Century II Fluoroscopic
Pagitane Hydrochloride	201	Slant Radiographic Unit 104
Provell Maleate	241	Pitman-Moore Company
Tes-Tape	235	Novahistine 225
Theracebrin	183	Procter & Gamble Company, The,
Trinsicon	243	Ivory Handy Pads BC
Ultran	245	Professional Printing Company, Inc.
Lloyd Brothers, Inc.		Histocount Products 214
Doxinate with Danthron 172	173	Pyramid Rubber Co.
Teracebrin Trinsicon Ultran Lloyd Brothers, Inc. Doxinate with Danthron Roncovite	24	Pyramid Rubber Co. Evenflo 236
		Rexall Drug Company
McNeil Laboratories, Inc.		Rexall Super Plenamins 281
Butiserpine	263	
Butisol Sodium	191	Riker Laboratories, Inc. Medihaler 73
McNeil Laboratories, Inc. Butiserpine Butisol Sodium Flexin 217 MacGregor Instrument Company	. 218	Pentoxylon 267
MacGregor Instrument Company		Rauwiloid 279
Tandem Tip VIM Gabriel Aspirating	r	Robins Co., Inc., A. H.,
Syringe	89	Donnagel 275
Managarill Common The C. P.		Donnagel 275 Donnagesic Extentals 326, 327
Massengill Company, The S. E., Obedrin	01	Donnagesic Extentass 326, 327
Obeurin	01	Donnatal 311 Pabalate (all forms) 204, 205
Mead Johnson		rabalate (all forms) 204, 205
Deca-Mulcin Deca-Vi-Caps Vi-Sols Family	247	Roerig & Co., J. B., Antivert 110
Deca-Vi-Caps		Antivert 110
Vi-Sols Family	69	Atarax 253
Vi-Sols Family Medical Case History Bureau Info-Dex		Antivert 110 Antivert 255 Bonadoxin 72 Obron 20 Stimavite Tastitabs 29
Info-Dex	324	Obron20
Medical Fernamics Inc. 100 200	200	Stimavite Tastitabs 29
Medical Economics, Inc. 192, 202	. 020	
Medical Protective Company Malpractice Insurance		Viterra 332
Malpractice Insurance	316	Porce Inc. Wm H
Merck Sharp & Dohme, Div. of		Viterra 332 Rorer, Inc., Wm. H., Maalox 76
Merck & Co., Inc. Altepose Meprolone 5		
Altenose	IBC	Sanborn Company
Menrolone E	4 55	Visette
Marrell Common The West C	. 00	Sandor Pharmaceuticals
	45	Colonact Colonact
pactical company, the win. S.,	40	Visette 199 Sandoz Pharmaceuticals Cafergot 257 Schering Corporation
Bendectin	200	
Merrell Company, The Wm. S., Bendectin Tace	- IP C	Chl (Tolored Do A. L.
Lace	- IP C	Chlor-Trimeton Repetabs 65, 66
Lace	- IP C	Chlor-Trimeton Repetabs 65, 66 Meticorten 229
Bendectin Tace Minnesota Mining & Mfg. Co. Thermo-Fax Copying Products	- IP C	Chlor-Trimeton Repetabs 65, 66 Meticorten 229 Metreton 27
Minnesota Mining & Mfg. Co. Thermo-Fax Copying Products	- IP C	Chlor-Trimeton Repetabs         65, 66           Meticorten         229           Metreton         27           Trilafon         176, 177
INCE	- IP C	Cafergot         257           Schering Corporation         65, 66           Chlor-Trimeton Repetabs         65, 66           Meticorten         229           Metreton         27           Trilafon         176, 177           Scholl Mfg. Co., Inc., The,         316

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#### INDEX OF ADVERTISERS

Searle & Co., G. D.,	
Dramamine 8	2
Pro-Banthine 308, 30 Zanchol 272, 27	9
Sherman Laboratories	
Protamide	9
Riasol 7	9
Smith, Kline & French Laboratories	
Acnomel Cream & Cake21	
Compazine Ampuls 34	
	6
Cytomel	3
Daprisal 9 Dexamyl 50, 5	9
Dexamyl 50, 5 Dexedrine 10	Į.
Teldrin Spansule	1
Trisocort-Vasocort 34 3	5
Trisocort-Vasocort 34, 3 Troph-Iron 7	í
Spencer Industries Auto Emblems	
	Ö
Squibb & Sons, E. R., (Div. of Olin- Mathieson Chem. Corp.)	
Florinef-S Lotion/Ointment 33	
Noctec Pentids 9	
Pentids 9	1
Raudixin 27 Sumycin 318, 31	0
Theragran 5	7
Toloppor Toloppol	7
Strasenburgh Co., R. J.,	
Strasenburgh Co., R. J., Biphetamine Resin 8	5
U.S. Vitamin Corporation Arlidin 40, 4	1
	•
Wallace Laboratories, (Div. of Carter Products, Inc.)	
Milpath	
Miltown Insert between 296, 29	
Wampole & Company, Inc., Henry K., Verapene	
Warner-Chilcott Laboratories	7
Agoral 350	7
A 1 11 1 1-1 C 14 201	5
Anusoi nemorrnoidai Suppositories 30	5
Anusol Hemorrhoidal Suppositories 307 Gelusil 270	5
Gelusil 270 Pacatal 74, 71	5
Gelusil         270           Pacatal         74, 71           Peritrate         344	7
Gelusil         27           Pacatal         74, 71           Peritrate         34           Plestran         22	7
Gelusil         27           Pacatal         74, 71           Peritrate         34           Plestran         22	7
Gelusil         27           Pacatal         74, 7           Peritrate         34           Plestran         22           Proloid         8           Pyridium         25	5 0 7 0 5 1 7 7 1
Gelusil         270           Pacatal         74, 77           Peritrate         34           Plestran         22°           Proloid         86           Pyridium         25           Tedral         21	5 0 7 0 5 1 7 7 1
Gelusil         270           Pacatal         74, 77           Peritrate         344           Plestran         22°           Proloid         8°           Pyridium         25i           Tedral         21           Westwood Pharmaceuticals	7
Gelusi	7
Gelusi	7711
Gelusi	7711
Gelusi	7 7 1 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
Gelusi	7 7 1 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3
Gelusi	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
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08, 309 72, 273 209

50, 51 105

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10, 41

4, 185

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8, 99

317

, 256

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